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## VALEDICTORY TO THE CLASS OF 1901, COOPER MEDICAL COLLEGE.

By GEORGE B. SOMERS, M. D., Professor of Gynecology.

It becomes my pleasant task, on behalf of the Faculty, to say a few words to you, the members of the graduating class and your friends, on the eve of your departure from Cooper Medical College. For the past four years these walls have witnessed your efforts in the laboratories, lecture rooms, clinics, and library, in preparing yourselves for the practise of medicine and surgery. The work has been hard and exacting, requiring the greatest industry and the closest application of which you were capable. It is safe to say that you will always look back on these years as the best of your lives, as far as work accomplished is concerned. You will probably never again do so much in so short a time, and the more you think of it, the more pleased and surprised you will be at your own capacity. You have received instruction from many different professors on many different subjects, and each one of you is supposed now to know what all the professors put together know. Truly this should be a proud moment, and by all means enjoy it to the utmost, before you begin to realize that there are a few more things to learn.

Again, within the limits of your college course you have gone over a field of knowledge which it has taken centuries to develop. Aesculapius and Hippocrates have been long dead, but the tree under which they gave their discourses on the art of healing is said to be still living. Their teachings are as dead as they are, but the spirit with which they taught still flourishes. In the cause of combating disease and improving the health of mankind, these great teachers set an example of enthusiasm, unselfishness, desire for truth, and lofty aims, which has characterized the profession in all ages and been the inspiration of many famous men. And when we come to inquire what has been accomplished by the united work of the profession, we find that the record is something to be proud of. It is true that many things have been learned only to be unlearned, and many things done that were better left undone, but the struggle for improvement has been unceasing. The voluminous writings, the innumerable journals, and the vast number of societies devoted to medicine, all attest the efforts of the profession. The problems to be solved are necessarily of a very difficult nature, but the advances already made in knowledge of disease have been wonderful. You, as students, are only too well aware of the countless facts which study and research have brought to light, and which have combined to clear up our understanding of disease. But to sum up in general terms, we may say that disease has been enormously diminished, epidemics are practically under control, the general standard of health has been raised, and the average length of life has been markedly prolonged. With all this you are familiar, and you have been shown the methods by which these results have been obtained. All that the past has accomplished stands as a stimulus and encouragement for your future work. The prestige of great names, great deeds, and an honored profession are your inheritance, and you are about to assume the responsibility of carrying on the work in a worthy manner. Can you imagine the condition of things, not so many years ago, when to take up the practise of medicine was like taking a leap into the dark? The chief equipments of the doctor then were courage, hope, enthusiasm, and confidence that his search for knowledge would be rewarded.

The conditions to-day are greatly changed. We are no longer compelled to grope about in the dark. Rays of light shine from many different directions. We have to guide us well-known laws, scientific methods, many instruments of precision, and the accumulated experience of the past. It is the custom nowadays for nearly every physician to establish a laboratory in connection with his office, in order that he may have the aid of science constantly at hand. We are conscious that our present knowledge gives us immense power over disease. In the great realm of surgery we are masters of the situation. In contagious diseases our methods of treatment are based on scientific principles, and we attack them with the greatest confidence. Smallpox and diphtheria are practically under control, and it remains for you to overcome in similar fashion the next two diseases on the list,—tuberculosis and typhoid fever. How have you prepared yourselves for the task?—You have acquired the necessary knowledge and experience entitling you to enter the ranks. Your training has developed certain qualifications of mind necessary to impartial judgments in estimating the various factors that influence disease. Compare yourselves now with yourselves as you were before you took up the study of medicine. You will find that your powers of observation, your methods of thinking, your ideas, your associations, your interests have all changed. These points distinguish you from your neighbors, and mark your professional character. They do not make you better than others, but make you different—necessarily so—because henceforth you are to become observers and advisers rather than companions of men.

Grant that you have all the knowledge that science can give. Is this sufficient to insure your success? You will find that there are other qualifications, partly natural, partly acquired, which must go hand in hand with science. Let me quote you something from Dr. Oliver Wendell Holmes. He says, "Science is a first-rate piece of furniture for a man's upper chamber, if he has common sense on the ground floor; but if a man has not got plenty of common sense, the more science he has the worse for his patients." This is no reflection on science, but means that a physician must temper his knowledge with sympathy and a kindly spirit. As an example, take any simple case of sickness to which you may be called. Science will tell you that you can find out a great deal about the man's condition if you examine him systematically. Therefore you thump his chest, run a tube down his throat to examine the stomach contents, and stick pins into his skin in order to examine his blood. On the other hand, judgment may tell you that the man is not very sick, and that all he wants is to be assured of the fact and made comfortable.

Doctor Conan Doyle in one of his short stories illustrates this point very well. He tells of two young physicians, both energetic and up-to-date, who settled in a small country town. They were cordially received by the old doctor, who had most of the practise of the district, for he would gladly have been relieved of much of his work. But the patients still clung to him, while the young men, with their modern ideas, newest remedies, and latest instruments, were neglected. They both liked the old doctor personally, but privately agreed that he was away behind the times, and that patients were really entitled to better treatment than he could possibly give with his old-fashioned ideas. One day, during an epidemic of influenza, when all three were worked to death, one of the young physicians was taken sick. As he lay upon a sofa, with a splitting headache and pains in every joint, he felt that he must have medical advice without delay. He first thought of his young scientific friend, Doctor Patterson; but the idea of him, with his cold, critical attitude, his endless questions, his various tests and tappings, became repugnant. What he wanted was something more soothing and more genial, so he decided to send for the old doctor. "Mrs. Hudson," said he to his housekeeper, "would you kindly run along to old Doctor Winter, and tell him I should be obliged to him if he would step round?" She was back with an answer presently, saying, "Dr. Winter will be around in an hour or so, but he has just been called in to attend Dr. Patterson."

How far to extend sympathy to patients, and how much to use cold science, are to be learned by experience. Each has its value, and neither should exclude the other. A physician's influence over patients is multiplied many times when it is found that he has human feeling as well as skill. In fact, it is astonishing to find that a large part of the community require of their medical advisers little education, little knowledge, and little or no sense, provided they are always good-natured, never hurt, and never give any medicine stronger than sugar and water.

Again, a very necessary adjunct to success is enthusiasm. In order to keep abreast of the times, sharpen your wits, and make your work attractive to yourself and others, you must cultivate enthusiasm. This leads to fresh and lively interest in all medical topics, causes you to see in each new case points of difference over other cases of the same variety, leads to many revelations and discoveries, induces you to discuss your cases with others, report them, and study them with ever-increasing proficiency. Without enthusiasm one drops into a groove, where all cases look alike, where the same remedies are used over and over again, where you will lose interest in your practise except from a commercial standpoint, and your patients will lose interest in you; and before long the probabilities are that about the only evidences you can give of belonging to a noble profession are the possession of a tall hat, a long coat, and a beard.

The practise of medicine develops a philosophy of its own, the chief characteristic of which is optimism. The cheerfulness of the doctor is proverbial. He has the reputation of laughing at you when you come to him with a long face; and yet you know that he is not frivolous, or disposed to make light of matters that are really serious. Things that appear to others frightful or awful have for him no terrors. Death itself he reckons with calmly and face to face, without allowing his calculations to be disturbed. He knows the worst and knows the best, and finds that, all in all, the good far outweighs the bad. Sad things happen, but in the course of a lifetime the joys and blessings and happy outcomes of trouble are vastly in the majority. Of this he is certain, and, taken together with the power over disease which knowledge gives, he knows that the chances of winning the battle over sickness and pain are all in his favor. How can he help being confident, hopeful, and cheerful? And being so, his patients are inspired with the same qualities. Medicine has no use for pessimism, and the doctor who looks on the dark side of things, and is filled with forebodings, will not be given many opportunities for displaying his opinions.

There is a quotation which I am sure you will hear many times, as soon as you give any one the opportunity of using it. It is, "Physician, heal thyself." You know how to care for others, and why should you not look out for your own health? Who would think of employing a sickly nurse to preside over a sick-bed. The presence of ill health is most depressing upon the sick, while the presence of the strong, ruddy, healthy, and cheerful acts like a tonic. And so with the doctor; if he does not keep himself in the best of health, he is not only open to sly jokes on the art of healing himself, but is really incapacitated from doing justice to his patients. I once had a very satisfactory little patient, who had unbounded confidence in my ability to cope with disease. One day he heard that I had myself been sick. This was a great shock to him, and he never again looked upon me with the same confidence. He afterwards said to his mother, "I don't see how a good doctor can get sick." The child's remark is very suggestive. A good doctor should not get sick. If he knows the laws of hygiene, of diet, of recreation, of rest, and of sleep, he should follow them as religiously as he prescribes them. He should be a living example of the laws of health. It is true that from the very nature of practise irregular meals and hours of sleep are often unavoidable; but proper management will make such irregularities the exeception and not the rule, or, at least, provide compensatory rest and nourishment where lost. Physicians are not a long-lived class, because they do not take as much care of themselves as they do of others.

To the graduate nothing is more interesting than a study of the life that lies before him. Each has probably made a mental picture of the position he intends to carve out for himself. But nowhere in that picture do dreams arise of ease, luxury, the acquisition of sudden wealth or widespread fame. These are not among the allurements attracting to this profession. He who takes up the study of medicine must know that the compensations are of quite another sort, and that, if any life can be called "strenuous," such is the life of the doctor. His rewards are not from the multitude, and not proclaimed before the public, but come from the bosom of the family or from close personal relations with the individual, in the form of esteem, gratitude, and love, in return for deliverance from suffering or the saving of life. I can not imagine anything that brings out the best qualities of human nature better than the relations of doctor and patient. In his own circle the doctor is a powerful moral influence, rising at times higher even than that of religion. He cheers the sick, lifts the despondent with hope, and leads the wayward back to the paths of health and proper living. Doctor Bard gives an apt quotation on the refining and far-reaching influence of the true physician, which I can not do better than repeat: "It has been my personal fortune to know such a man. It has been my privilege and delight to accompany him in his visits, where his chief medicines were the personal presence and conversation of the man himself. He had shared and lessened their anxiety, counseled the wayward, had led the sick back to health, cheered the weakhearted, had rejoiced with them that did rejoice, and wept with them that wept. And I have seen such a man so surrounded by an atmosphere of love and trust, holding, as it were, the heartstrings of a family in his hands, their guide, philosopher, and friend; and then I realized what a moral force in society the profession, properly comprehended and properly followed, was capable of exerting, and how relatively small as part of its usefulness was the administration of medicine." I think this description brings home as vividly as it can be expressed the responsibilities awaiting you. Knowledge is great; but character, morality, and sympathy are greater still.

Just a word more regarding your future relations with your Alma Mater. With each succeeding year her family of sons and daughters grows larger, and consequently her sphere of influence widens. But she flourishes in proportion to the success of her graduates. What they do reflects directly upon her. Where they succeed, she shares in the success; and if any one fails, she feels it deeply. If I may express her sentiments and dearest wishes, they are that her family may be a united one, and go on increasing in numbers, influence, and good works, that her children may take interest in and support her efforts toward a higher education, that they may rejoice in each other's success, and, above all things, take a just pride in being graduates of Cooper Medical College.

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# TREATMENT OF CANCER OF THE UTERUS.

By J. HENRY BARBAT, M. D.

*Read before San Francisco County Medical Society, March 17, 1901.*

The treatment of cancer of the uterus is a subject which has taxed and is still taxing the ingenuity of the medical profession, and, as far as a solution of the problem is concerned, we are still groping around for some efficient means to combat successfully this most horrible disease. We must necessarily admit our inability to cure this disorder when we find that the only rational method of dealing with it at present is by removing completely every vestige of tissue which is or may be involved in the destructive process. We have so far no cure for cancer of the uterus. By this I mean that we know of no method that will arrest the proliferation of epithelial cells, and restore the affected tissues to their normal condition. Until we discover something which will accomplish this, we can not claim that we can cure cancer. Our treatment must then be directed to the removal of the diseased tissues; and the method which enables us to accomplish this with the greatest degree of thoroughness is the one which we should adopt. Various means have been advocated to attain this end; actual cautery, chemical caustics, electrolysis, freezing, injections of various materials into the diseased tissues, and last but not least, the removal of the disease by surgical means.

In the present state of our knowledge, the only means which is permissible, except in cases of undoubtedly inoperable cancer, is the last, namely, the complete removal of the uterus, its adnexa, and, if necessary, the lymphatic glands connected with it. This brings us to the question, What constitutes an inoperable case? A case may be considered inoperable when we find that the disease has extended into parts which can not be safely removed, or has involved structures at a distance from the original disease, indicating that metastases have taken place. The amount of tissue which can be removed with safety must necessarily depend on the skill of the operator and the physical condition of the patient. Again, a case may seem to be an operable one until the surgeon opens the abdomen and finds that the broad ligaments are infiltrated as far as the wall of the pelvis, or finds that other organs in the abdomen are involved. With regard to unfortunate cases which baffle our operative skill, they will, of course, furnish the material on which we must depend for the discovery of a specific for cancer of the uterus. We are certainly justified in experimenting on these cases in our endeavor to find a cure for this disease. The treatment of inoperable cases resolves itself into the alleviation of the symptoms which are present. Hemorrhage is to be treated by curettage and cautery, the ligation of the uterine arteries, the application of pure formalin, and tampons. Pain must be relieved by opiates. Thus far we have not been able to show any positive results from the administration of drugs by the mouth, or the application of remedies to the diseased structures. All improvements which have been obtained by local applications have been due to the fact that the cancerous tissues were destroyed by the caustic action of the drug employed, and as the destructive process can not be limited to the diseased structures, it is impossible to completely remove cancer of the uterus by this means. The inoculation of toxic bacteria or their toxins has not proved to be of any benefit in cases of true cancer of the uterus. We must, therefore, turn to the surgeon for the present if we expect to cure the disease by removing the affected tissues from the body. Two routes are in vogue, one through the vagina, and the other through the abdomen. Except in cases where the disease has just begun in the cervix, or where pregnancy exists, the abdominal route is undoubtedly the best. If we examine a uterus which has been removed through the vagina, and compare it with one that has been removed through the abdomen, we will find that the first has less tissue attached to it than the other, because in removing the uterus by the abdominal route it is possible to cut close to the pelvic wall, and therefore to reduce the chance of recurrence, while through the vagina the operator is obliged to keep near the uterus, and can not even under the most favorable circumstances make as wide a cut. In operating through the abdomen we are permitted to inspect the rest of the abdominal contents and determine whether we are justified in proceeding with our operation, or whether it is better to close the abdomen on account of our inability to remove the entire disease. Furthermore, it is impossible to remove the lymphatic glands through the vagina, and as it has been shown that in a number of cases cancer cells are found in the iliac glands, we should remove them in all cases. If we begin our work through the vagina we may find, after having proceeded so far that we can not recede, that the case has advanced much further than we had any conception of, and it is necessary to leave it half finished, with the result that the second state of the patient is worse than the first, because the partial removal of cancerous growths stimulates what is left to a rapid extension, with the possibility of inoculating sound tissues in the vicinity. It is better to leave a cancerous uterus alone, unless we can remove every vestige of diseased tissue, the only excuse for a partial operation being for the relief of hemorrhage. If we find that the uterus is movable, that the broad ligaments are not thickened, that the finger in the rectum proves it to be free from involvement, that the bladder is not infiltrated, that no metastases can be discovered, then we are justified in advising the radical operation. Cases are found, however, which appear most favorable for operation until the abdomen is opened, when it will be seen that the disease has made too much progress to permit its safe removal, and we are forced to close the belly without any further procedure.

From the operator's standpoint, carcinoma of the uterus may be divided into carcinoma beginning in the cervix and that beginning in the body. In cases of the cervix in which cauliflower excrescences have made their appearance, it is better to remove all the projecting tissue with a sharp curette before opening the abdomen. This may be done a few days previous to the main operation. Before beginning the operation it is advisable to introduce bougies into the ureters, in order to facilitate locating them and avoiding injuring them during the course of the operation. When the abdomen is opened and the case is considered favorable, the operation is begun by tying the ovarian vessels close to the pelvic wall, and cutting between ligatures. The round ligaments are next tied and cut, and the bladder separated from the uterus and broad ligaments. These are then opened and the ureters dissected free to the point at which they enter the bladder. The uterine vessels are now tied as close to their origin as possible, and cut. We now proceed to separate the vagina from the bladder in front and the rectum behind, to within about an inch of the outlet; then comes the most difficult part of the operation, the separation of the vaginal fornices from the base of the broad ligaments, the attachments being very strong. The assistant now grasps the cervix or what is left of it with a strong volsellum, and makes traction; this draws the uterus out of the abdominal cavity and down through the vagina, leaving it projecting at the vulva. The next step consists in the removal of the lymphatic glands situated at the bifurcation of the common iliac arteries. It is necessary in order to remove these glands to slit up the peritoneum, and they should be removed with great care and delicacy, in order that no infectious material be driven into the general circulation through the lymph channels. The lumbar glands are rarely affected. The edges of the peritoneum are now sewed together, beginning on one side at the point where the ovarian vessels were tied, and going across to the corresponding point on the other side. This cuts off the abdominal cavity from any possibility of infection from cancerous tissues below. The abdomen is now closed, and the uterus and upper part of the vagina removed by ringing the vagina at the angle formed by its reflection, either with the thermo cautery or the knife. The large cavity which remains is packed with gauze, and closes by granulation. This is the operation devised by Werder, of Pittsburg, and is the only one which can be considered as radical, and the best so far with regard to the prevention of recurrences.

There are a number of complications which may arise in the course of this operation, the most formidable of which is the involvement of the ureters in the cancerous process. As a rule, only one ureter is involved, and it becomes necessary to remove the diseased portion and make an anastomosis between the proximal end and the bladder, being careful to close the distal end so as to prevent leakage from the bladder. Hemorrhage is another ugly complication, and will sometimes tax the skill of the operator to the utmost. If the hemorrhage is arterial it is due to the uterine artery or one of its branches, and the quickest way to control it is to make pressure on the common iliac, which is always accessible. This enables the operator to either find the bleeding point or to remove the diseased tissues without further loss of blood. Cases of cancer of the uterus which are complicated by pregnancy are fortunately rare, and usually require immediate operation. If the disease has not advanced too far, it has been found that vaginal hysterectomy offers the best prospect of recovery, as it is easy of performance; the uterus, being soft and pliable, can be drawn almost outside of the vulva after it has been evacuated of its contents. In cases in which the cervix is extensively involved, and the surrounding tissues indurated, it is best to do a Porro operation if the child is viable.

When the cancer is limited to the body of the uterus, it is not necessary that the upper portion of the vagina be removed, but it is imperative that the operation be done through the abdomen, because in this class of cases we find that the disease may reach the inoperable stage even before the patient has the slightest idea that she has anything wrong with her. Before opening the abdomen it is better to sew up the mouth of the uterus, in order to prevent any of the cancerous secretion from being squeezed out during the manipulations necessary for its removal, as it has been shown that a new focus of infection may be developed by the contact of this secretion with an abraded surface. It is also essential in these cases that the ovaries and tubes be removed in toto, and that the lymphatic glands be completely excised, as we find recurrences in these structures if left behind.

With regard to the prognosis after operation, it depends entirely on the stage of the disease, and the quality and position of the cancer. The best results are seen in cases of adeno-carcinoma of the body, and the poorest in adeno-carcinoma of the cervix. The most essential feature in all cases is to make an early diagnosis.

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# ACUTE NEPHRITIS IN THE EARLY STAGE OF SYPHILIS; X RAY BURN.

By Douglass W. Montgomery, M. D., Professor of Diseases of the Skin, University of California.

*Read before the California Academy of Medicine, April, 1901.*

Whether or not acute nephritis may be caused by the syphilitic poison is a question. There is, of course, no way of telling that a nephritis occurring in a man with syphilis is caused by the syphilis. One can only say that it would be strange that such a generalized poison, that does give rise to acute inflammation of other internal organs, should spare the kidneys. Karvonen, in his exhaustive work on syphilis of the kidneys, says that acute nephritis is very rare, and was only able to collect out of the literature nineteen cases where acute nephritis was probably caused by syphilis.* To those nineteen he has added one of his own, making twenty in all. The first of these twenty cases was reported in 1863, and the last in February, 1900, that is to say, considerably less than a case a year.

On Feb. 25, 1895, an Irishman 49 years of age was sent into the clinic for diseases of the skin, from the surgical clinic, by Dr. J. M. Williamson. The patient had a very large, indurated chanchre on the belly, in the median line, just above the pubic hair, with immense swelling of the lymphatic nodules in both groins, with a few papules, some papulo-squamous lesions, and a fading roseola of the skin. There were mucous patches in the mouth. He was drowsy, had headaches, and a coated tongue. On being told the nature of his malady, this man was for "cleaning out" the clinic. Then, the origin of his troubles becoming definite to him, he announced he would go home and "clean out" the household.

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*"Die Nieren Syphilis," von Dr. J. J. Karvonen, "Dermatologistiche Zeitschrift," Bd. 7, S. 37.

His wife drank, and was of a roving disposition, and the excrescence on his belly was the result of her return home at Christmas. He was given proto-iodide of mercury pills internally and mercurial ointment topically for the chancre.

On March 6, nine days after I first saw him, he had a large mucous patch over almost the whole palate, and, for some reason I have now forgotten, the mercury was stopped, and he was given iodide of potash in ten-grain doses, with black wash for a mouth wash. On March 18, 1895, twelve days after his last visit, and presumably about the fifty-second day from the first appearance of the chancre, he again came to the clinic, with the following symptoms:—

There was marked edema of the lower limbs and scrotum and slight edema of the lower conjunctival folds. He was very sick and weak. The urine was clear, amber colored, acid, with a specific gravity of 1.022, and with cold nitric acid there was a copious precipitate of albumen. Albumen was also found with heat and acetic acid, and Esbach's test showed the quantity of albumen to be one gram to the liter. There was no sugar. Microscopical examination showed uric acid and oxalate of lime crystals, some pus corpuscles, and numerous hyaline casts, with some small, round cells stuck to them, and granular casts. There were no red blood corpuscles in the urine, and not many leucocytes. The patient had not been exposed to cold, nor had he been drinking, nor was he a drinking man. He had never had scarlet fever, nor diphtheria, nor rheumatism, and his heart and blood-vessels were normal. He had never had gonorrhea, nor any trouble with his urinary organs previous to the present nephritic attack. The patient was sent to the City and County Hospital, and the iodide of potash was continued in fairly large doses. He remained about ten weeks in the hospital, and, on leaving, the urine was perfectly free from albumen and casts, nor has any ever been found since. The hospital notes have been lost, and I therefore can not give the quantity of urine passed.

On July 29, 1895, he again returned to the clinic, with circinate papular syphilides of the left forearm and left lower extremity. His urine was clear amber colored, with no albumen and no casts. There was no complaint of symptoms referable to the kidneys or bladder. The iodide of potash treatment was continued. On May 18, 1896, it was noted that the scar where the primary sore had been was white, with a pigmented border. He had tubercular syphilides of the back, of the left arm, of the front and right side of the neck, and of the forehead. There were some mucous patches in the mouth. His general health was good. On April 1, 1896, he entered the clinic, complaining of hoarseness, and pain and edema over the lower part of the shin bones. There was a syphilitic papule on the anterior surface of the left wrist. The iodide of potash treatment was still continued.

On Nov. 16, 1896, the patient returned, with some mucous patches on the tongue, and then, for the first time since the affection of the kidneys, he was given mercury, one grain of hydrargyrum c. creta, three times a day. I did not see the patient again until May 14, 1897, when he presented himself, with a superficial slough of the anterior aspect of the gums of the lower jaw, and five tubercles of the eyebrows. He was then given a mixture containing corrosive sublimate, a sixteenth of a grain, and iodide of potash, ten grains to the dose. On April 27, 1898, there were two patches of herpes on the right side of the penis, and there was swelling of the left leg, and a tender thickening over the left tibia. On April 19, 1901, that is to say, a few days ago, he came again, complaining of a pain in the left popliteal space, radiating down the front of the leg. He was again given corrosive sublimate and iodide of potash, and by April 22 the pain was almost entirely gone. The urine was examined for albumen, and none found, but he complained of frequency of micturition while taking the medicine.

This is an instance of acute nephritis occurring at an early stage of syphilis, and as he was not taking mercury at the time of the nephritic attack, and as he has since taken mercury without any nephritis developing, it is clear that it was not mercurial nephritis. And, as he took iodide of potash during the attack, and without causing nephritis, it is clear it was not an iodic nephritis. In the same way may be excluded an acute nephritic attack in the course of a chronic nephritis, or nephritis from alcoholism, from exposure to cold, from rheumatism or gout, or the acute infectious diseases other than syphilis. In this way we are reduced to accepting a nephritis due to some unknown cause, but fortuitously occurring in the course of early syphilis, or a nephritis due to syphilis. Strongly in favor of the view that the nephritis in this patient was due to syphilis is the time at which the nephritis developed. It will be remembered that we first observed the symptoms of nephritis about the fifty-second day after the appearance of the chancre. Now Karvonen draws attention to the fact that, in those cases which he designates as acute nephritis probably owing to syphilis, the nephritis had developed very early in the course of the syphilis; in one-third of the cases the nephritic attack had begun only two months after the appearance of the chancre; sometimes even, as in our own patient, the chancre had not yet healed. In the greater number of the cases the nephritis had developed in the third month after the appearance of the chancre. After the first year it had been found to occur very rarely.

As regards treatment, some recommend iodide of potash, others both mercury and iodide of potash, and some prefer mercury alone. In the case in hand iodide of potash was given throughout, as being less irritating to the parenchyma of the kidneys than mercury.

The prognosis seems to be fairly good. In the present instance the patient seems to have fully recovered, having had no relapse during six years.

### AN X-RAY BURN.

On March 15, 1901, a patient came to me, suffering from an X-ray burn, received the previous November. He had been exposed, he told me, to three sittings before a plate machine.

There was an irregular, shallow ulcer on the belly, to the right and below the level of the navel. The ulcer had red, inflamed borders, and was covered with a yellow, leathery, tightly-adherent coating, with here and there a red granulation peeping up through it. It was excessively painful and tender, and was especially painful at night. The patient said that it had healed over a very considerable portion of its original area, but latterly it had come to a standstill.

An ointment, composed of the red oxide of mercury, camphor, carbonate of lead, lanolin, and vaselin, was prescribed, which did fairly well for a time. Then lead and opium lotion was prescribed; then balsam Peru. Then, at the suggestion of Dr. Pring, a 10 per cent lotion of lysol was given, which was found to be the best for the control of the pain. It did very well for a time under this, but latterly, on returning to work, the patient had another relapse.

## THE GENERAL AND LOCAL TREATMENT OF DIPHTHERIA.

By W. B. Lewitt, M. D., Associate Professor of Diseases of Children, Medical Department, University of California.

*Read before the San Francisco County Medical Society, Feb. 12, 1901.*

The use of antitoxin in the treatment of diphtheria has produced such a revolution that other therapeutic measures are looked upon to a certain extent as only supplementary to the principal remedy. While I stand as an ardent advocate of the early and vigorous use of antitoxin, I have not yet arrived at that frame of mind that would lead me to depend in all, or even in the majority, of cases upon the good effects of that agent alone, and while each succeeding year tends to increase my confidence in its efficacy, yet I believe that our success will be increased by attention to certain general and local measures. In regard to the general treatment of the disease, we should have one object in view above all others, that is, to maintain the strength of the patient by rest and the administration of food and stimulants. A child ill with diphtheria should be put to bed and kept in a recumbent position until convalescence is well established. Those about him should be cautioned against allowing him to sit up or to exert himself in any way. In cases showing any indications of cardiac weakness, not only must these precautions be strictly observed, but directions be given that under no circumstances is the child to be raised for the administration of foods, stimulants, medicine, or for any other cause.

The food should be given at short intervals—every two or three hours—and in quantities as great as can be assimilated. I am sure that when we keep the blood well charged with the products of digestion, the formation of toxins is to a great extent inhibited, and we should therefore insist strongly upon the regular administration of food. The best is milk; it may be diluted, or, what is better, more or less completely peptonized. In children under five years of age this should be the only article of diet. In those older, and in adults, we may add eggs beaten up with the milk or lightly boiled, also soups and gruels. I wish to call attention to the frequency with which ice-cream can be given to children when other food will be refused, and to the fact that they will often take milk when it is flavored with cocoa, coffee, or tea, when they will not take it plain. In some cases there is an absolute refusal to take food, either from the distaste or from the pain and difficulty of swallowing. Under these circumstances we have to resort to forced feeding. Personally, I have no confidence in rectal alimentation. It is unusual for a child to retain the enema, and it is a question as to how much is absorbed. With a child under 2 years of age there is no difficulty at all in getting a catheter into the stomach by way of the mouth. In older children, up to the age of 5 years, it will be found better to pass it through the nose, and then, by the aid of a funnel and a foot or two of rubber tubing attached to the catheter, any desired quantity of food or stimulants can be administered, and vomiting does not often follow if the precaution be taken to withdraw the catheter quickly, grasping or pinching it tightly, so that there will be no trickling of fluid into the pharynx. In those over 5 years of age, it is generally a question of moral suasion as to how much food can be given. In the majority of cases of diphtheria, stimulants are called for. In some cases, where the membrane is confined to the tonsils and there are no indications of systemic infection, it would seem that stimulants are not required; but, as occasionally happens, the amount of toxins produced does not seem to depend upon the location or extent of the membrane, it is certainly the safer plan in all cases to begin the administration of stimulants early, not waiting for the evidences of beginning cardiac failure. By the early use of stimulants, we can frequently lessen to a marked degree the effects of the toxin, particularly upon the cardiac muscle and pneumogastric nerve. In those cases where the extent of membrane is larger, particularly if the nasal cavities are involved, then more urgent is the call for the early use of stimulants. We have to depend to a great extent upon alcohol given in the form of brandy, whisky, or champagne, in doses varying according to the age of the patient and the effects produced; and we are astonished in some cases to see the amount that is necessary to keep a flagging heart up to the mark. When giving brandy or whisky to children, it should always be well diluted, at least one part to eight of milk or water, and often the addition of lemon or lime juice and sugar to the water will be an aid to its administration.

Next in importance to alcohol is strychnia; given hypodermically and in severe cases in children it can be given in doses out of all proportion to the age of the patient without producing any symptoms of poisoning. It is not uncommon to give a child 5 years old from $\frac{1}{100}$ to $\frac{1}{60}$ of a grain every three hours, keeping this up for several days. With a rapid, compressible pulse, showing low arterial tension, digitalis is of benefit, but its use is restricted because of the frequency with which nausea is produced.

Strophanthus may be substituted for digitalis, but it is generally less reliable. If we can not get the results desired by the use of the remedies mentioned, I do not believe that any benefit will be derived from ammonia, ether, camphor, musk, or other stimulants that are recommended. Regarding the internal administration of bichlorid of mercury, calomel, chlorate of potash and iron, I can only say that I do not use any of these except the latter, and that ordinarily only during convalescence. I might also make an exception, as far as calomel is concerned, which I give as conditions seem to require, not for any expected effect upon the diphtheritic process, but as we give it in many instances for its action upon the gastro-intestinal tract. I do not wish it to be understood that I do not appreciate the value of these remedies; they have been most useful in the past and of course are at the present time, when we can not obtain the particular remedial agent that has almost entirely supplanted them. But as we are discussing diphtheria from what might be called an up-to-date point of view, I do not think it necessary to consider the methods of treatment that have become more or less obsolete. It is when we come to consider the question of local treatment that we observe the marked changes in opinion that have occurred during the past few years. And again, I do not intend to take you back to former times and dwell upon the relative values of the almost numberless agents that have been used as local applications, but rather to give the results of my personal experience during late years. I, like most of you, who have been more than a few years in practice, was accustomed to the use of tincture of iron, carbolic acid, lactic acid, hydrochloric acid, nitrate of silver, and other drugs having a more or less destructive effect upon the tissues. Do you recall the struggle with the resisting child during your attempts to use the swab or spray, when it would take the combined efforts of three persons to accomplish your purpose, and with what result?—The patient thoroughly exhausted, his lips and mouth bruised and bleeding from lacerations of the mucous membrane; a more or less complete application not only to the diphtheritic membrane, but to the healthy tissue of the throat and mouth. I am speaking now of cases that we most frequently see, that is, in children under 10 years of age. Now is there anything to be gained by this procedure? It is utterly impossible to completely or even partly rid the affected cavity, whether nose, throat, or larynx, of the bacilli. If we use agents of sufficient strength and quantity to be germicidal, we are going to do as much harm to the patient as we do to the bacilli. We may kill a few of them, but at the same time we take chances of poisoning our patient, and we generally destroy or injure more or less mucous membrane and open new fields for the growth of the germs. Where the membrane is confined to the tonsils, and these constitute the majority of cases, local applications are not necessary. But when we find the pillars of the fauces, the uvula, the posterior wall of the pharynx, and, more particularly, the nasal cavities involved, local applications may be of benefit. I say, may be of benefit, for to my mind it depends to a great extent upon the behavior of the patient. If the application can be made without much difficulty, well and good; but if it means a prolonged struggle with a child whose heart muscle is weakened by toxic degeneration, I maintain that it is not well and good and had better be abandoned.

In diphtheria of the nasal cavities, naso-pharynx, and pharynx, ordinarily all that can be accomplished by any drug, used locally, can be done by warm sterile water. By its use we can keep the parts clean; we can wash away the bacilli that are on the surface of the mucous membrane, waiting for a favorable opportunity to develop toxins; we can soften and dislodge pieces of membrane; and we have an application that is soothing and often grateful to the patient. The idea is that by sending a stream of water through the nasal cavities, we irrigate these cavities, the naso-pharynx, and the pharynx. There is generally much less difficulty in doing this than in making the ordinary application to the throat, and it has the very great advantage that the patient does not have to be raised from the recumbent position. He is placed on his side with a rubber sheet and towels beneath the head and neck, and if the patient is old enough or is particularly tractable, a fountain syringe may be used, but generally a soft rubber aural syringe holding from three to four ounces will be found most convenient, particularly in infants and children. The nozzle is to be inserted horizontally into one nostril, the bulb quickly compressed, and before the patient has a chance to resist the operation is complete. This is to be repeated upon the opposite side. To be of benefit we should be certain that the fluid returns through the other nostril, through the mouth, or is swallowed. Generally we will find that it returns both by the other nostril and the mouth. In case the nasal cavities are so blocked with membrane that the water can not be forced through, it becomes necessary to make a passage with a large probe, and this can be done if the prcaution be taken to pass the probe parallel with the floor of the nose and as near that surface as is possible. Of course, you will meet children who resist so violently that it is best to desist, but it is the exception;

or you may find that the hemorrhage from the nostrils following each irrigation is so severe that they can not be continued. This procedure is to be repeated several times a day, according to the severity of the case. Where the nose and naso-pharynx are involved and in septic cases it should be done every hour or two, each time using from eight to twelve ounces of water. Normal salt solution is also used. While it is less irritating than plain water, still in some cases where large quantities are used a sufficient amount may be swallowed to produce vomiting, a disadvantage that is not often noticed when plain water is used. It is in cases of laryngeal and tracheal diphtheria that we frequently see the most marked results of the use of antitoxin. It is in the same class of cases that great benefit can be obtained from local treatment.

At the Children's Hospital we have had quite a number of desperate laryngeal cases, most of them sent in from the outside when the disease was well advanced. Our results have been so good that the methods used can certainly be recommended. There is nothing new or original about it, it simply being the use of the vapor of water and the fumes of sublimed calomel. If it is possible, we make use of two adjoining rooms; in each is a bed having over it a canvas tent. The child is put into one of these beds, and then with a Whitall-Tatum croup kettle a more or less constant stream of medicated vapor is thrown into the tent. To each pint of water used in the kettle, I add half a dram of creosote. Once in every two, three, or four hours the child is taken from this tent to the one in the other room, and in this latter from 15 to 30 grains of calomel are sublimed. He remains in the tent inhaling the calomel fumes for from 15 to 30 minutes. He is then returned to the bed first occupied, and the room used for the calomel fumigation is thoroughly aired. A common method of subliming calomel is to put an alcohol lamp in an ordinary chamber, then lay across the top a strip of tin two or three inches wide, and over the spot where the flame of the alcohol lamp touches the under side of the tin make a little pile of the amount of calomel to be used. A very much more convenient apparatus is this lamp constructed by Ermold, of New York, for the purpose. It can be hung up by the wire, and then there is no possible chance of any accident due to the movements of the child. It often happens that the child will have some paroxysm of coughing during the calomel fumigation, but this is rather an advantage, as it tends to dislodge pieces of membrane. I have never seen any bad effects produced either on nurse or patient, although in some cases this treatment has been kept up for four or five days. It is said that occasionally stomatitis and diarrhea result. The interval between the fumigations is to be increased as the evidences of laryngeal obstruction diminish. In severe cases the patient is kept in the vaporizing tent continuously except when undergoing the calomel fumigation. In cases of moderate severity there are intermissions of one or two hours. The relief to the breathing is generally marked, and I am certain that in many cases the necessity for intubation or tracheotomy is done away with and life is prolonged until the good effects of the antitoxin become manifest. Owing to the effects of the warm vapor in relaxing the tissues of the larynx, the spasmodic attacks occur much less frequently and are less severe. The detachment of the membrane is hastened, and possibly the creosote has some effect in inhibiting the growth of the bacilli.

Calomel is considered by some to have a germicidal action. It probably aids in the disintegration of the membrane, but its principal benefit is supposed to be due to the protection afforded the mucous membrane of the larynx, trachea, and bronchi, and in preventing the extention of the membrane downward. I do not consider emetics to be of any value except in those rare cases when a peculiar flapping sound accompanies inspiration or expiration, showing that a piece of membrane is partly detached. Under those circumstances the detachment may be completed by the act of vomiting.

## MEASLES; COMPLICATIONS INVOLVING THE EAR AND EYE.

By A. Barkan, M. D., Professor of Ophthalmology, Otology, and Laryngology, Cooper Medical College, San Francisco.

*Read before the San Francisco Medico-Chirurgical Society, March 4, 1901.*

*Ear.*—Complications on the part of the ear during and after measles occur more frequently and are of greater importance than is generally supposed. Recent researches reveal the rather surprising fact that inflammation of the middle ear forms a regular link in the chain of ophthalmological events during an attack of measles. The result of post-mortem examinations, made on the third day after the eruption of the exanthema in complicated cases of rather severe type, showed in nearly every case the lining mucous membrane of the middle ear intensely reddened and containing a discharge. The otitis media, though a fairly regular non-concomitant affection of measles, is fortunately of a mild catarrhal character, especially when acompanying a mild epidemic, takes a sluggish course, very rarely in those mild cases perforates the membrana tympani, and usually ends in recovery. In the severer cases a rapid necrosis of the substance of the membrana tympani occurs, acute caries may develop and require opening of the mastoid antrum, and death may be caused by cerebral complications. Blau has given us a careful study of the course of 130 cases of otitis media due to measles. I will mention only a few data: 8 times the drumhead was nearly entirely destroyed; 30 times caries of the mastoid; 7 times caries with cholesteatoma; 8 times the labyrinth was affected with necrosis; 15 times the external canal was entirely filled with polypi. In round numbers 70 patients were cured, some of them with seriously-damaged hearing. About 50 remained uncured, and, what is most striking, 11 died from intracranial complications following the ear trouble. These fatalities, almost without an exception, could have been prevented by an early and rational treatment of the acute middle-ear attack. With reference to the time of occurrence, the ear complication generally shows itself in the beginning of the general affection or during desquamation, exceptionally during prodromal stage; many cases of measle-otitis, however, remain latent, probably when amount and virulence of microbes present is slight. In all cases of measles early complications in middle-ear infection probably occur through the blood, while the later ear complications are very likely due to infection from the eustachian tube. It is interesting to state that neither in the ear nor in other places has there been found any specific micro-organism as the cause of measles, other than the usual variety of germs, mostly cocci.

Of preventative measures the patient should be directed to blow the nose "miner's fashion," that is, with one nasal canal always open, so as to prevent passage of nasal discharge and infectious germs through the eustachian tube into middle ear. Dobell's solution or listerin 1 to 5 might be sprayed into the nose and naso-pharynx. Above all, every case of measles must be closely watched from the beginning, and properly treated if aural disturbances show themselves, if fever lasts beyond the usual time, or if it shows itself anew after it has once disappeared. Proper treatment in the beginning will often prevent mischief, and both parents and physician must be aware of their responsibility. The treatment of simple cases coincides in a measure with that of the general disease,—warmth of body and ear, rest, action of the bowels, in cases of pain, warm ear baths of 4 per cent boracic acid lotion; into the external canal 5 per cent to 10 per cent carbolate of glycerin will generally prove soothing; repeated leeching behind the ear and in front of the tragus; and where indicated, prompt and liberal paracentesis of the membrana tympani. If perforation has occurred, hourly cleansing with syringe, or irrigation with hot aseptic solution, and a narrow strip of gauze as a drain into the external canal. Astringent solutions are rarely indicated. Swelling in the region of the mastoid and sensitiveness of touch call urgently for leeching and icebag, the latter kept up day and night.

*Operative Procedures*—Wilde's cut in the milder cases, eventually opening of the antrum mastoid. Watch early; treat early and radically, which will, in many of the serious cases, prevent fatal mischief to hearing in life.

*Eye.*—General practitioners have come to consider an ocular affection at the commencement of an attack of measles as among the earliest and most characteristic signs. A well-marked catarrhal conjunctivitis, with increased secretion, sensitiveness to light, and lachrymation, are the conditions present. Complications on the part of the cornea are rare, and the conjunctivitis usually passes off without treatment before the stage of desquamation is reached. In rare cases the conjunctiva assumes a slight blennorrheal character; then the cornea may be endangered. These catarrhal cases come oftener under the observation of the general practitioner than the oculist. The latter has a more frequent opportunity, however, of seeing ocular lesions, which occur after the primary trouble has entirely disappeared, and which are doubtless dependent upon dyscrasia produced by the general affection. There occur a number of strumous eye affections during the two or three succeeding months, such as phlyctenular ophthalmia, vascular keratitis, and marginal blepharitis. Among other troubles during this period paresis of accommodation may also occur. Whilst the general run of eye troubles complicating measles are of a slight character, occasionally more serious affections of the eye may occur, and blindness result from them. Several cases of optic neuritis have been observed, generally complicated with meningitis. Woods divides the cases of blindness after measles into two classes, first, those showing no eye lesions until late in the history of the case; second, those with marked neuritis from the beginning. The former are apparently due to cerebral lesion, probably vascular, with consecutive nerve disease, the latter to basal meningitis and neuritis. Optic neuritis may also occur as a secondary result of measles, the communicating link being furnished by the otitis media and invasion of the brain. The ocular lesion is either the result of meningitis, due to the ear disease, or is one of the affections of general pyemia. Fiezel describes spontaneous gangrene of the eyelid as a sequel of measles. The treatment in cases of conjunctivitis is very simple,—a solution of boric acid applied as a wash and a little vaselin rubbed in the edges of the lids at night. The room should be slightly darkened, and cocain may be used with or without atropin. The eye affection following will call for proper local and general treatment. The first consists of calomel, massage with yellow oxid, outdoor exercise, and general hygienic treatment.

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## MEASLES: COMPLICATIONS INVOLVING THE GASTRO-INTESTINAL AND RESPIRATORY TRACTS.

By Dr. Jos. O. Hirschfelder, Professor of Clinical Medicine, Cooper Medical College, San Francisco.

*Read before the San Francisco Medico-Chirurgical Society, March 4, 1901.*

We must remember, in studying the complication of these two tracts, that there, is in measles, an erythema of their respective surfaces, an erythema which is analogous to the eruption which we see upon the skin.

To begin at the beginning, the eruption may be seen in the mouth, where it causes phenomena which are very important, with the exception of the diagnostic Coplic's sign. Occasionally there are aphthae, and also rarely, in very poorly-nourished subjects, the dreaded noma.

In the stomach the erythema sometimes results in a slight gastritis, almost never in anything more serious.

In the intestines the erythema extends over the inner surface, which produces an appearance somewhat resembling that found in typhoid fever. There is a redness of the entire surface of the bowel, together with a swelling of Peyer's patches. This erythema in the intestine produces symptoms of a diarrheal nature, which symptoms are more or less severe according to the greater or less intensity of the rash upon the inner surface of the bowel.

In the respiratory tract there may be produced from the same erythema upon its surface various conditions, according to the location of the rash. If it is severe enough in the larynx, there may be a laryngitis; further down there may be from the same cause trachitis or bronchitis. Still it must be remembered that while the rash is the same on all these mucous surfaces as on the skin, its appearance is somewhat different, in that, while the latter is arranged in spots more or less closely grouped, the former is seen as a uniform red blush, a generalized hyperemia.

This hyperemia in the bronchial tubes may become very intense, and lead even to atelectasis. If, superadded to this inflamed surface, there are pyogenic substances (I hope the bacteriologists will forgive me for suggesting that there may be other causes of the disease than bacteria), and these extend into the aveoli, then pneumonia may follow.

This is the way that pneumonia develops as a complication in the course of measles.

Tuberculosis may also develop as a complication in two ways, first, from the inside, endogenically; second, from the outside, exogenically. The endogenic route: this may be scrofula. Scrofula is minor tuberculosis of the lymphatic glands.

It is not always possible, or at any rate has not in the past been possible, to demonstrate this fact microscopically; however, if the following technique be followed, the bacilli may usually be seen:—

The enucleated gland is to be placed in a two-per-cent pyrogallic acid solution in 95 per cent alcohol, allowed to remain in this solution several days, changing the fluid each day. Then it is taken into alcohol and washed; then the sections are made and stained in the usual way. Bacilli are found in all scrofulous glands, and in many, if not all, of the lymphatic glands of healthy persons. This fact was proven by Loomis, of New York.

The exogenic route may be either direct or indirect.

First, the indirect way: In measles there is a tremendous hyperemia and a tremendous lymph stream through the lungs to the general blood-stream. Through the bronchial glands this stream flows, and if the bronchial glands be infected with tubercle bacilli in large numbers, they are swept on in the current of this great stream of lymph from the glands into the general circulation, and tuberculosis is the result.

Infection occurs directly when, because of the hyperemia of the mucous lining of the bronchi, the tubercle bacilli from the outside, gaining direct access to the inflamed and congested surface, find it a favorable soil, and develop there, reinforcements as well coming in directly from the outside to the respiratory passages on the inspired air stream.

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## CESAREAN SECTION (PORRO OPERATION).

### Report of Cases.

By Z. T. MALABY, San Francisco.

*Read at Meeting of the Medical Society of the State of California, April 16, 17, 18, 1901.*

The value of a careful examination, both general and local, of a pregnant woman can not be overestimated. The mortality rate of parturition has been diminished during the last ten years, but it still continues high, mainly because a thorough examination of the patient months before the expected event is neglected. As a result, the obstetric surgeon is not prepared, until labor sets in, to treat that which might have been avoided or checked by prophylactic measures. Again, a careful estimate of the size and conformation of the maternal pelvis, thus ascertaining whether or not there is a disproportion between the bony structures and fetal head, is the secret of success in a large number of cases.

Pelvic deformities are comparatively rare in this country. Relative pelvic contraction, a pelvis of average size which is yet too small to admit of the passage of an overlarge child, however, is common. A pelvis can only be said to be contracted when a particular head can not adapt itself to that particular pelvis. This can not be measured; it can only be estimated. A good rule in midwifery is the following: Any head, no matter how large, which can adapt or engage itself in a pelvis, no matter how small, can safely pass through the pelvis. The recent advances in the study of the contracted pelvis, and the possibility of saving fetal life in such cases, by the extension of the major operations to a wider field, have revolutionized this subject. It will require time yet, however, before the old prejudice among physicians and laity, engendered by reason of the unnecessary large mortality which accompanied these operations, can be eradicated. Statistics which embrace operations performed ten, or even five, years ago are of little value, inasmuch as the technic has been so modified and perfected that results are entirely different.

Once the practitioner realizes what the public is already beginning to know, that the loss of a child in labor from mechanical obstacle is a loss which might probably have been avoided; once he recognizes what will, in my opinion, before many years be recognized by the profession far and wide, that the mortality and morbidity of the major operations done at the beginning of labor are no greater and probably less than those of violent and prolonged forceps extraction, very few children of multiparae will owe their death to any mechanical cause.

The operation known as Cesarean section is no longer postponed until the mother's vital forces have been spent in unsuccessful attempts, either on her part or on the part of the obstetrician, in delivering the fetus in the natural way. Formerly it was thought best to wait for the woman to go into labor before the operation was begun; but in those cases where it has been predetermined that the operation is necessary, it is far better to elect the time of its performance. Cesarean section and symphysiotomy compared, observations being based on, (1) Leopold's results of 100 Cesarean sections; (2) Pinard's results of 90 symphysiotomies; (3) and personal results of both procedures at the Liege Maternity. With complete asepsis the mortality of Cesarean section should not be over 5 per cent. It is a better operation than symphysiotomy, on the grounds that, (1) it is easier to perform, since no special instruments are required; only soft parts are cut through, and these are exposed to view; any hemorrhage is easier to control, and the operation is quickly finished; while in symphysiotomy much of the cut part is out of sight; after the point is severed there is still the difficult task of delivering the baby, for which purpose obstetrical forceps are generally needed, and serious tears of the soft parts are likely to result; (2) it is safer as regards hemorrhage and injury to adjacent parts, just as safe as far as sepsis is concerned, and it has a less tedious convalescence, with no fear of a loose pelvis, though there is slight fear of ventral hernia. (Charles L'Obstet., Nov. 15, '98.)

*Indications.*—1. When the mechanical relations would render forceps or version unusually difficult, forcible, and prolonged, and, when the mother is in the favorable class, the equally low maternal mortality and the far lower fetal mortality of Cesarean section make it the operation of choice. 2. When the mechanical conditions make the intrapelvic delivery of an intact child at term impossible or unduly difficult, the great superiority of the Cesarean section over the induction of premature labor in fetal mortality and its extremely low maternal mortality render it again the preferable operation. 3. Carcinoma in a pregnant uterus at times justifies this operation. 4. It is also indicated in a severe case of ante-partum sepsis. 5. It is permissible, if the mother is moribund and the child is known to be alive, where rapid delivery by the natural passage is impossible.

Technic of Porro operation: Perhaps of no other operation can it be said that the application of the rules of modern aseptic surgery has accomplished so much as in the one under consideration. Strict asepsis, four assistants, incision six inches, equal distance above and below umbilicus; seize uterus by left upper corner, lift out, close incision partly above; place rubber tube around cervix, crossed, but not tied, to be tightened as necessary; incise uterus in median line four to five inches. If placenta is on anterior wall, it will cut through; if waters have not broken, avoid soiling peritoneum. Introduce right hand, extract child by head if possible, if not, by extremities; tie cord, divide. Remove placenta. The uterus is then amputated just above the rubber tube, stump cauterized, silk sutures uniting raw surfaces, and stump treated extra-peritoneal.

### REPORT OF CASES.

Case 1. Mrs. H. G., admitted to the City and County Hospital, Oct. 14, 1900, prima para, age 22. The patient was a very small woman, which led us to apprehend difficulty in labor. Feb. 11, 1901, labor pains set in, and continued for some hours, with no effect. The symphysis was erect, the promontory high, and the true conjugate was estimated at about 8 cm. It was thus decidedly a small pelvis; but on dilating the os, the patient being under ether, and seizing the child's head with the hand, it was evident that the head was a large one. However, the forceps were easily applied, but two strong tractions failed to advance the head into the brim. The mother and child being in excellent condition, Cesarean section, Porro operation, was performed by Dr. James F. McCone, assisted by myself and the house staff, with an uneventful recovery for mother and a living baby of eight pounds.

Case 2. Mrs. V. P., aged 38, entered the City and County Hospital April 25, 1900; examination per vaginum revealed a kidney-shaped pelvis, antro-posterior diameter measuring 5 cm. Pains commenced during the night of May 1, and continued for twelve hours, with no apparent result. The forceps were applied, patient under ether, and gentle traction was made, with no advance. Condition of mother and child being excellent, Cesarean section was performed, Porro operation, by Dr. James F. McCone, assisted by Dr. M. B. Ryer and myself. Mother left hospital in nineteen days, with a fine boy weighing twelve pounds.

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## IS MARRIAGE A FAILURE?

By HENRY HILDRETH, Delano, Cal.

*Read at Meeting of San Joaquin Valley Medical Society, March 12, 1901.*

I am sorry I am obliged to appear before you with a question for the second time, always with a question, never with an exhaustive treatise settling a mooted medical point to the satisfaction of the profession at once and forever. This I do because I am so constituted, not that I would much prefer to solve problems, but I am not intellectually built that way. It is beyond my capabilities, but I am of a curious turn of mind, and seek enlightenment upon such topics as more nearly concern the race of which I am a part so inconsiderable as to form no factor in the solution of this problem. If I was the whole Christianized portion of the Aryan race, I could answer very readily, as I have had individual experience of a character most conclusive. But the experience of one individual, or a minor percentage of the whole Christian world, does not settle this much mooted question, a question that was and is and will be forever, a question that presents several sides for inspection. Taken in the concrete it admits of no unqualified solution, but must be studied from several standpoints. It must be first analyzed and isolated from a lot of foolish dressing, given by God knows whom, but as much changed from its original condition by modern dressing as the jackass who was draped in the skin of the lion.

Legal marriage makes its appearance in history, first as a law promulgated by Moses, with a definite purpose, as he himself sets forth. His people were about to possess lands in severalty, and in order that a father, a land owner, should know his children, a law of marriage was instituted, and a decree against adultery, intended for the guidance of the wife, was enacted and engraven on the tablets of stone, so that property could be devised in legitimate succession. This law, promulgated for the benefit of 400,000 Jews, is to-day the fundamental principle on which rests the social fabric and legal statue of 400,000,000 of people, and is the law by which unnumbered millions of property is devised. Therefore, most undoubtedly for the purpose intended by Moses, marriage is a success. As a social factor it has been criticized by many writers, some of great ability, others of cynical tendencies, but all with a grievance, perhaps from an unhappy experience of their own; but as the Christian race continued to marry and obey the law as a whole, an occasional outcry from a disappointed one does not affect the entire social fabric. We, it seems to me, should cease to question a law that has existed nearly 2,400 years, and, with modifications, affects Christian, Mohammedan, and not a few Pagans alike. Marriage, as a law, is "time tried and fire tested." The laws of all Christianized lands recognize marriage legal, and permit marriage ecclesiastical to be binding, and in some codes marriage by ordained church officers is legal as well. Legal marriage is recognized as a contract, which costs little to enter into, but is expensive getting out of, something like a California building and loan company. This is not as it should be. A contract, which for its consummation requires only mutual consent, should be just as readily dissolved and by the same means. The reverend gentlemen, who are authorized to solemnize or acknowledge the marriage contract, think otherwise, and some denominations go so far as to declare that God Himself joined these two and only death can legally sever. Looked at from this point marriage very frequently fails. Moses in his marriage law did not intend it as a religious rite; if so, each marriage would have been entered into with solemn ceremony, in the presence of the "ark of the covenant," "the house of God," who at that time was giving His individual attention to the Jews alone, a task afterwards abandoned in the time of Jephthah, the last Jewish leader to gain a victory. Moses did not, in the statute made and provided in and for all marriage cases, place any particular restrictions on the number of wives a man should have, but states whom he should not marry for reasons of consanguinity and previous conditions of family or nature and servitude. All of these negations are good to-day, and wisely or unwisely more are added. A considerable proportion of the earth's population believe in a paucity of wives and a multiplicity of husbands, so that polyandry is recognized, and we are told by travelers who claim to know, that the offspring of polyandry is a sturdy, vigorous race, of vast physical endurance, and much shrewdness, although the rate of increase is low, and the history of divorce courts is a blank.

In lands of the highest civilization woman is not granted so much. The modern law, both statutory and canonical, allows but one husband at a time to each woman, which is showing the female population more favor than Moses did, who ruled one husband, or such a fraction of one, as the mental disposition of the husband chose to give her. Moses was himself a little liberal in the matter, as he married often enough to get himself into trouble, even if he had lived in a liberal town like San Francisco or Denver. But it is with the amended law of Moses,—I do not say improved, but amended by the efforts of the clergy,—that we in our temperate zone have to deal. The question of failure is only heard in a land wherein one husband is ruled to one wife, and is not allowed to carry joy and consolation to the heart of another, and the woman is under the same restriction. And the aggravation of it is somewhat to be attributed to the expense, difficulty, and disgrace of dissolving a contract that is irksome and unpleasant to both parties. We need only to live and read to know that the greatest men and the greatest minds come from the monogamist dwellers in the temperate zone. We are not yet ready to submit the case. Those nations and peoples who believe with Moses, David, and Solomon, remain to be considered, and they form no part of the earth's population, and the quantity and quality of polygamy is not altogether deficient in physical or mental attributes. At one time a very large portion of the monogamous Catholic world was conquered, and for several centuries held by the polygamous sons of Ishmael, under Mohammed and his followers. So, to make deductions, polyandry is not a failure entirely in the climate and environment in which it is practiced, although it might appear to us of the San Joaquin Valley as decidedly unsatisfactory, viewed even in the abstract. Monogamy, which we are ruled to live under, being a decided improvement, and to our younger members perhaps considered susceptible of further improvement by removal of restrictions. Polygamy has its advantages, and could, no doubt, be ably defended if its supporters could be permitted to state their case and advance their arguments. One argument alone will be stated here, and that is, that in polygamous countries there is no divorce court.

I would enjoy reading a complete and exhaustive statement of the advantages and disadvantages in a legal and social way of the various marriages numerically considered. A history of those few tribes, isolated and abandoned, who have no marriages would also interest the scientist. The rate of increase and the law of natural selection and the results therefrom would add to our statistics, and would perhaps aid us in our search for a perfect system by which a perfect generation might be secured. So much in consideration of the subject from a legal standpoint is merely an allusion to which I leave you to think volumes in addition, but it is sufficient to establish the fact that the matrimonial knot properly tied is no failure, and socially is an established success, no matter whether it is fractional, unital, or multiple. But the standpoint from which it be viewed by the scientist, is whether or not it has failed in the genesis of the race? It is claimed by some that we are growing weaker but wiser; this is a disputed point; moreover it is not the desideratum at all. We want to grow stronger and wiser, and the question is, whether if in mating by marriage we are following an improper or a proper course to attain our object. Could our present custom of marriage be improved upon to the benefit of the race, and how? Shall we trust to "natural selection," and how? Shall we trust to "natural selection" or shall selection of a mate or mates be settled for us? And if the latter, who shall select?—Why, the scientist, the man of attainments, the doctor, of course. And why not? All previous experiments have failed because made by soldier or law-givers. The memorable experiment of Lycurgus achieved a great success, manifest after 400 years, but the excellence attained in four centuries of time vanished in a generation. The great Frederick's scheme came to naught, so it is left to some future generation to try again, and the selection must be trusted to a committee of those who know most of genesis, and are best prepared to skilfully differentiate between those who should and should not become the parents of a new race of more perfect, healthy physique and larger mental endowment. In order that an experiment of this kind might be tried, the first concession to be obtained is the consent of the nation experimented upon, at present an impossibility; then the appointment of scientists to study the different conditions of polyandry, monogamy, and polygamy. This would also be difficult if the scientist selected was allowed the privilege of declining the proffered honor. We may take our own little society here, and I venture that a committee to spend five years in polyandrous countries would be difficult, if not impossible, to obtain. Whereas, if a committee was called to spend five years or twenty-five in polygamous studies and practices, this seventy would volunteer in a body. We, as guardians of the public health and morals, know full well that a perfect offspring can not be begotten by an imperfect ancestry; and if perfect and improved offspring is the object of marriage, then it is a reasonable deduction that those affected with moral obliquity and physical defect or constitutional disease should not marry. But a difficulty would arise even if a decree to this end were made a welcome law. If enforced, it would cut down the perquisites of the justices and the priesthood, but would utterly fail to reduce copulation, and copulation is the source of production. To effecutally rob this dereliction of its natural consequence would necessitate the arming of each and every practicing physician with the knowledge and instruments necessary to perform a rapid, safe, and effectual "hypospadias" or ovariotomy. The classes to whom should be denied the privilege of procreation will be by common judgment varied and in the aggregate numerous; and over individual cases there would be much difference of opinion, and the result would be a general social disturbance and political cyclone, in comparison with which the French Revolution would be but a zephyr. But "what would the harvest be?" Would the result justify the means? If only the physically and mentally perfect were allowed to procreate would the resultant generation be perfect or even of a more perfect standard than we have at present? If the physically and mentally qualified were obliged to be married as a preliminary to procreation, would it still improve matters and add to the perfection of the generation? For my part I see no logical reason why a human being could be made better or worse by a contract made and entered into by his parents before the necessary copulation towards his begetting had taken place? I can see how a vicious example could lead a child into vicious habits, but first the child must be born to be influenced either rightly or wrongly. Very few children ever inquire and seek evidence to prove the fact of marriage on the parts of parents, which in many cases had best be left to conjecture. The division of an estate is the most potent factor instigating such an investigation. I notice that in the social and business affairs of life we meet and value a man according to his attributes, and ask no question in regard to his paternity. We well know that the offspring of great men are never so great as the sire, the offspring of the athelete is not always athletic, the offspring of the beautiful not always beautiful, and here comes in the question of environment. The son may have the same climate and surroundings as the sire, and greater advantages, or what we consider improved conditions, and yet fall far below the sire in every quality in which the sire excelled. This holds true also in regard to the maternal influence. The Mohammedan nations in seeking to improve their stock depend more on the maternal than paternal for excellence in offspring, the result being about as satisfactory in one case as in the other. Taking the names great in history all social conditions are represented. Great men seem to be a by-product, not the regular thing, as it were. Some say genius is a neurotic condition, and the fact that they are far and away superior to others, is cited as proof, and in decades more or less after the individual has joined the silent majority his genius is recognized and his monument erected. But by this time his genesis is forgotten. Data are not obtainable that would guide us in the selection of proper individuals, the mating of whom would result in great excellence, physical and mental. Marriage may cement in a measure and fully sanctify a union, but attributes of offspring are distributed or bestowed by a power or rule of which we of this generation know nothing. I, for my part, believe in a marriage law, and just as firmly believe in a divine law; and I am convinced that in the interest of future generations the laws we have at present are susceptible of improvement. The edict from the Almighty was that the life of man should be of a like term as the life of Moses. The health and stature were not prescribed, neither the mental ability. For 2,400 years we have lived under the same laws, and have produced the same man oft repeated. No man has shown equal abilities with Moses, and none have been greater than Him, the God, that was born to us in Bethlehem.

## PROFESSIONAL JEALOUSY IN THE MEDICAL PROFESSION.

By J. J. McKone, M. D., Tacoma, Wash.

We often hear the reflection cast upon our profession that we are a class of intensely jealous people, and that doctors delight to belittle one another.

If we can stop to consider the matter, we can easily show that instead of being the narrow-minded individuals many people would give us to understand, we are, moreover, the most liberal minded of all the professions, with perhaps the exception of our legal brethren; and as it is the fashion of the latter in the pursuit of their calling to make as little of the work of their opponent as possible, they seem to react when outside of actual contests, and to give credit to their brother lawyers for any ability they may possess.

If one will compare our profession with that of any other, the difference becomes at once apparent. Take music, for instance; ask any of your friends among the local singers or performers, and notice how each one will deprecate the work of the other. Take the artists, and see how few outside of the recognized profession amount to anything in the opinion of your informant. Take the actors and actresses, and listen to them for a few hours. In the church, above all places where there should be no professional jealousy, is it most the marked of any; ask any newspaper man the result of giving one minister a little extra notice of his sermons or movements, and see the result among the balance. Why, some time ago, when our city paper was printing the sermons of a local divine, who is supposed to represent an advanced religion, with plenty of free thought and easy conscience, a delegation of the local clergy waited on the editor, and wanted to know why the rest of them could not have as much space as this "non-believer."

Go down the line, and take the trades. A man has only to consult his blacksmith if he wants to know how few men in the world besides himself really understand the art of taking care of a horse's feet. And he can conclude in half an hour that the medical profession is a band of angels.

It is only human nature that there should be a certain amount of failing in any profession, and the doctors are no exception to the rule. Success has at all times engendered animosity and envy, and the latter is the tribute inferiority pays to merit; but that it exists in a greater degree in medicine than any other profession, I refuse to admit.

A doctor is more liable to be irritated

into abusing a brother than any one else, for it is proverbial that patients misquote one physician to another, for obvious reasons, and a man is a man, no matter what his profession. But in what other profession will one member fulfil the duty of another without remuneration, as physicians do time and time and again?

Is there any other profession where a man being discharged from his client gives all the information in his possession to his successor, as the physician does? Did any one ever hear of a famous musician being supplanted by a rival, and then leaving his successor his instruments, that he might be able to fill the place? But we see this every day in our noble profession.

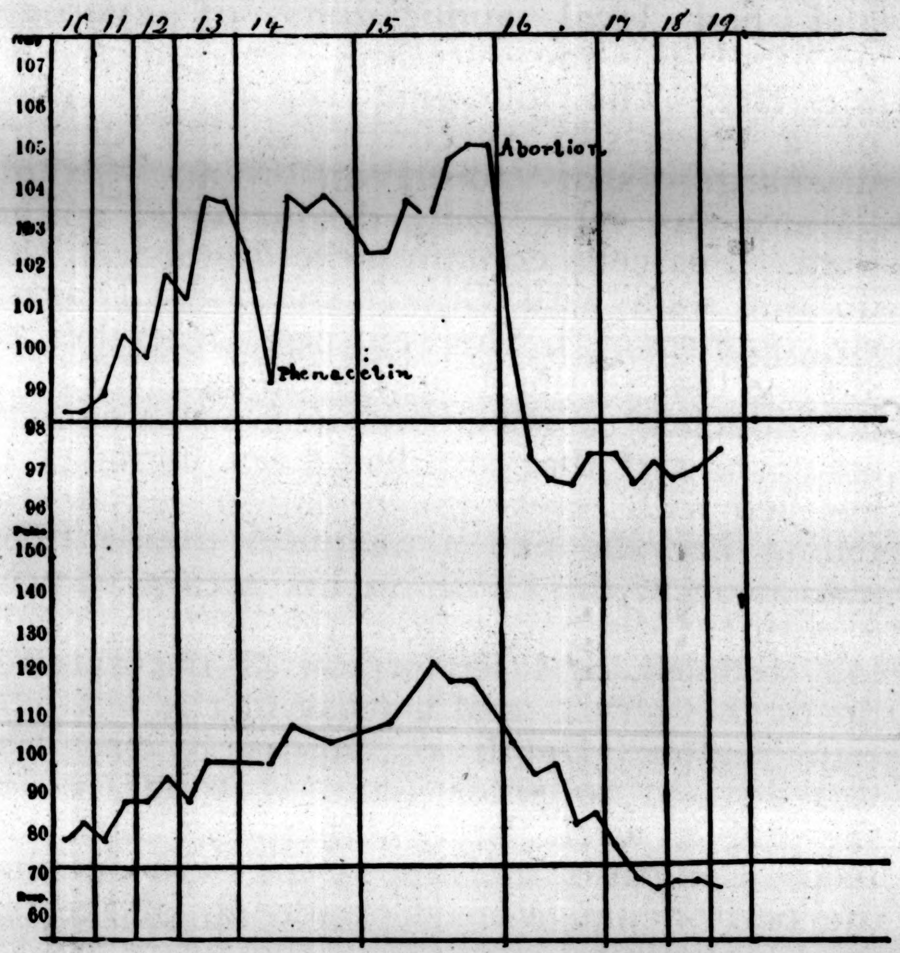
## HOSPITAL REPORTS.

**Gynecological Clinic, Cooper Medical College, Geo. B. Somers, M. D., in charge.**

*Reported by Minora E. Kibbe, M. D.*

### ABORTION WITH HIGH TEMPERATURE.

Hospital Case No. 114. Mrs. S., aged 35, three children, several miscarriages. Has always lived at a high altitude in Utah. For several years has suffered much from attacks resembling angina pectoris. The pain is paroxysmal, involving the cardiac region and extending down the left arm. The heart shows a slight aortic murmur. Liver somewhat enlarged; skin dark, sclerotic, slightly yellow. Patient became pregnant, and the angina increased much in severity. Advised to enter hospital and take rest cure. The case was not considered as true angina, but diagnosed as neurasthenia dependent on hepatic and gastric irregularities. Analysis of stomach contents showed 25 per cent total acidity. Stomach washed out daily; diet and bowels regulated. Hot compress applied over liver 4 or 5 times a day. Patient did fairly well for about 10 days, though she had almost daily attacks of pectoral pain. She then began to have a rise of temperature, which gradually increased until, on the sixth day, it reached 105.2 degrees Fahr. During the fever she had more or less pain in the back and region of the uterus. During the night of the sixth day the pains became expulsive, and a two-months fetus was delivered. The temperature then dropped to sub-normal. The discharge with the fetus had an offensive odor. On curetting, however, the interior of the uterus appeared perfectly sweet, and cultures made from lochial discharges and from inner walls of uterus were negative. Remarks: The fetus probably perished some days before its expulsion, and the high fever may be explained as a toxemia from beginning decomposition of secundines. Cases of induced abortion are quite frequently accompanied by high fever and symptoms that seem alarming, but usually all evidence of infection disappears at once on thorough evacuation of the uterus under strict asepsis. Below is given a chart showing the course of the fever. The sudden fall on the fifth day was due to phenacetin.



### NYMPHOMANIA; PHLEBOLITHS.

Hospital case 65. Miss E., age 29, cleft palate, undersized, poorly nourished, was bright and intelligent as the average child up to the age of 15. At this time she began to have dizzy spells every month for two years, but no menstruation. At 17 she menstruated, the flow being very scanty, and the dizziness developed into chronic spasms. For past 12 years the menstruation has been very irregular, occurring three or four times a year, but at each monthly period has had spasms. During the past two years she has grown much worse, threatened self-destruction and harm to members of her family. Has also developed nymphomania of severe type. The latter symptom became so unbearable that her friends consulted regarding measures for relief. While no promise regarding cure of epilepsy was held out, castration was proposed as a cure for nymphomania. In the operation the clitoris was dissected out, the labia minora amputated, tubes, ovaries, and uterus removed. The adnexa were found matted together. In breaking up the adhesions a number of nodular masses were found, which, when opened, showed white, cheesy matter. These were supposed to be tuberculous, but, on examination by Professor Ophuls, showed that they were soft phleboliths. The patient has not been relieved of the convulsions, but was cured of the erotomania.

### GONORRHEAL PYOSALPINX.

Clinic Case 2872: Married. Aged 22, one child, two miscarriages. On October 12 first noticed pain during and after micturition, and that blood was passed with the urine. Says the parts were swollen and the whole body feverish. Twice she visited the clinic and had local applications of hydrogen peroxid to the urethra, and then left the city. The following report was given of a cover-slip specimen of the urethral discharge, sent to Prof. Wm. Ophuls. "Many pus cells, some desquamated epithelium. Pus cells contain large diplococci, that do not stain with Gram's method. Diagnosis, gonococci." She returned December 20, stating that in the country she had had bladder douches of boric acid and permanganate solution, and that she had been confined to her bed with severe inflammation, her doctor telling her she had a phantom tumor. Examination at the clinic on her return showed a purulent discharge from the urethra, swelling, redness, and tenderness of the anterior lip of the cervix, and a mass in the left ovarian region. Depth of uterus 8 cm. She was advised to enter Lane Hospital, which she did a week later. Operation Dec. 29, 1900. Length of incision 15 cm. On opening the peritoneum, a mass, made up of the left tube, containing a pus sac, the ovary, and a coil of intestines, adherent to the fundus of the bladder, was found. The adhesions were separated, leaving raw surfaces about the size of a quarter dollar on both bladder and intestine. These spots were subsequently treated by drawing together with fine catgut sutures. The right tube and ovary were in fair condition, showing only a few adhesions; but it was deemed best to remove these also for fear of subsequent infection. Hysterectomy, with supra-vaginal amputation of the uterus, according to Kelly's method, working from left to right, was carried out. A swab dipped in carbolic acid was applied to the cervical canal before drawing the peritoneum over the stump. The repaired bowel was carried down into Douglas' pouch and the omentum drawn down over the intestines as far as possible. As a few drops of pus had escaped from the sac during the removal, the pelvic cavity was washed out with normal salt solution, about a pint being left in the cavity. The abdominal wound was closed in four layers, running catgut for peritoneum; two or three interrupted for muscle; chromicized catgut interrupted for fascia; subcuticular running for skin. At the time of operation cover-slip specimens were examined of the discharges of the urethra, cervix, and excised tubes. That from the cervix showed a few pus cells and no bacteria; the tubes showed pus cells, desquamated epithelium, but no bacteria; while that from the urethra showed many pus cells, a few desquamated epithelial cells, intra and extra-cellular, large capsulated diplococci, that did not stain with Gram's method. Remarks: Patient recovered rapidly. On the tenth day, while straining at stool, she felt a little pain in the wound. On examination the next day, the line of union appeared perfectly black, though not stretched. A puncture through the fine cicatrix liberated about two drams of dark, bloodly fluid. The parts were then dressed and no further trouble experienced.

### PRURITUS VULVÆ.

Clinic case 2877. Married, German, age 47, 7 children. No miscarriage. Menopause at 45. Diabetes mellitus. Has had itching about vulva for 6 or 7 years. Pruritus was so great that when she came to the clinic she could not sleep. Examination showed vulva very much thickened and enlarged, red and angry looking. The patient was treated with lysol douches and application of 4 per cent nitrate of silver solution to the vulva. She experienced the greatest relief at once, and inside of two weeks the inflamed condition entirely subsided. She continued attendance at the clinic at irregular intervals for about three months. During this time she learned the lessons of cleanliness, and was gratified to find that she could prevent all pruritus by the liberal use of lysol douches and washes. She then ceased to come.

# Occidental Medical Times

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## THE PLAGUE RESOLUTIONS OF THE STATE MEDICAL SOCIETY.

Through the kindness of Dr. Emmett Rixford, who proposed the resolutions which were passed by the Medical Society of the State of California at its last meeting, we are enabled to publish a correct copy, which reads as follows:—

> "Whereas, It has been shown by our local bacteriologists, and by the Commission sent by the United States Government, that the bubonic plague has existed in San Francisco, and probably does at the present time; therefore, be it
>
> "Resolved, That the Medical Society of the State of California express its confidence that the San Francisco Board of Health, the State Board of Health, and the United States Commission will be able to watch the disease, and to take proper measures for its suppression."

This correction renders the position of the state society much more satisfactory, and justly gives our local bacteriologists due credit for their very efficient and thorough work. In this note Doctor Rixford very appropriately says, "I wish the official report of this affair to contain reference to the fact that our local bacteriologists demonstrated the presence of the plague."

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## THE CONCEALMENT OF PLAGUE INFORMATION

The *Public Health Reports* of May 3, 1901, contain certain telegrams, which Doctor Wyman has caused to be published, with the endeavor, no doubt, to correct "the misstatements in certain daily and medical publications regarding an agreement made between officials of the Treasury Department and representatives of California and San Francisco—the only agreement entered into."

With all due respect and consideration for Doctor Wyman's exalted position, with full appreciation of what a denial means, and with sincere regret for him personally, we are forced to deny that this is not the only agreement, at least understanding, entered into. In our May issue we asserted, through *American Medicine,* that Doctor Wyman should explain certain telegrams and orders sent by himself and others who were parties to this transaction. As yet sufficient time has not elapsed for a reply, and, with due regard for whatever may be said in defense of his position, we, since that date, have secured certain information bearing upon our own and his position, that should be presented to the profession forthwith.

Part of this information emphasizes the fact that if no other understanding or agreement was "submitted," if no verbal understanding was reached, if no other written document exists or existed, we are positively assured that Doctor Wyman unfortunately has asserted that "this understanding" will prohibit his giving out the facts until he thinks it advisable to do so.

A careful review of these messages and telegrams fails to disclose the basis for the charges brought forward at various times by the *Evening Bee,* of Sacramento, and by the Occidental Medical Times. They do not mention the fact that Doctor Wyman gave orders to certain individuals that no information pertaining to plague should be given to the public, nor do they contain the extracts from his address of May 8, 1900. They do not tell why the chairman of the California delegation insisted that, if the inspector of the San Francisco Board of Health, who personally informed us, while in attendance upon a post mortem, of this fact, should find any cases, he should make no mention of them, as it had been agreed not to say or publish anything about plague. They do not contain the telegrams of Mr. Older or that of Senator Perkins; they make no reference to the statement that to secure harmony he felt convinced of the necessity of not giving out all the facts for publication. No reason is offered for the failure to report cases from Jan. 1 to March 9, 1901. They do not clear up the statement that "Gage, Spaulding, and Wyman" were ready to do anything. Nor do they explain why, on March 11, 1901, the Associated Press spread broadcast the following item:—

> "Washington, March 11.—In view of the persistent publication of the report that bubonic plague existed in San Francisco, the Treasury Department some weeks ago appointed a Commission of experts to examine into and report upon the situation there. THAT REPORT HAS BEEN RECEIVED AT THE TREASURY DEPARTMENT, BUT THE AUTHORITIES ARE NOT DISPOSED TO MAKE IT PUBLIC AT THIS TIME."

This positively asserts that the report was not to be made public. There is nothing in the agreement, published in the *Public Health Reports* of the above date, that refers to this disposition of the authorities.

Moreover, in evidence that the Commission and Doctor Wyman joined hands to suppress the truth, we offer the following episode to show how desperate and far reaching have been their efforts. On April 16, 1901, Mr. T. T. Williams, of the *Examiner,* representing the California Commission, went to Dr. J. H. White, of the Marine Hospital Service, and demanded that on no account must Doctor Kinyoun be permitted to speak or otherwise address the State Medical Society, then in session in Sacramento. He insisted that Doctor Kinyoun must be stopped immediately, and not even be allowed to go to Sacramento, which conclusively shows that something more than what Doctor Wyman has made public was "understood" at Washington, and it is certain that at least verbally Doctor Wyman and the California Commission, "the receivers of Wyman," had agreed to conceal the facts, and also that, when they wished to communicate with the "sick man," it should be done through Doctor White, thus not only endeavoring to throttle and conceal the truth, but to even deny to Doctor Kinyoun the privilege of free speech. Failing in this in San Francisco, Mr. Williams at once telegraphed to Doctor Wyman, demanding that Doctor Kinyoun be ordered not to go to Sacramento, or be allowed to address the Society on the subject of plague. The astonishing reply came back, "Has Doctor Kinyoun left San Francisco?" meaning, no doubt, as we are credibly informed, that, if he had not gone, his leave of absence would be revoked. It therefore is plainly evident that other agreements have been made, but not for the scrutiny of the public.

Without presenting more fully facts at our command, we, out of sympathy for our readers, for this extended discussion, brought about by personal malice and concealment of facts, will await explanations, and offer for further corroboration the following from the *Evening Bee,* of Sacramento, May 16, 1901:—

> "The fact is that not only did Surgeon-General Wyman make an agreement to suppress the facts, but he carried that agreement out until he was forced to abandon it by the publication of the infamy and the demands of other states.
>
> "The assertion made by the 'Bee,' that such an agreement had not only been made, but had actually been signed, was upon the authority of a member of the special Com-

> mission sent by the governor of California to Washington to prevent the publication of the report of the Federal Plague Commission, and to prevent drastic measures being taken against California in view of the report. Governor Gage had in the main been informed of the contents of the report by the members of the Commission before their departure. . . .
>
> "From an independent Washington source the 'Bee' was afterward informed that such an agreement had been been made, but not signed. The 'Bee's' informant in this regard would not have the same ~~means~~ of knowing what actually did occur as that possessed by a member of the Commission.
>
> "The records of Surgeon-General Wyman's own office will show that he sent instructions to the quarantine office at San Francisco for the non-publication of the facts."

That the agreement as published in these messages was made and partially adhered to, we have never doubted, but our contention is, and has been, that other agreements, or "understandings," verbal or written, have been made between the various interests to conceal the true state of affairs in Chinatown. These may not have been drawn up for the purpose of being signed, but ample evidence is at hand to show that they were made.

The history of this struggle is a remarkable instance of corruption, political debauchery, falsehood, and sacrifice. The infamous demands made by certain individuals upon men of honor will yet reap a proper reward. The consideration demanding the most thought is for the future, which presages nothing favorable.

It is a matter of deepest regret that the Surgeon-General of the Marine Hospital Service, from whom we expected so much in such an hour of trial, has seen fit to lend himself to such questionable transactions. We regret that an honorable service has been disgraced without any ostensible motive. It is almost inconceivable how, with all the facts, proofs, absolute knowledge of the existence of the disease, with every charge of malfeasance in office, ignorance, cruelty, brutality, murder, etc., refuted, and proven utterly false by public and private processes, by law and self-authorized investigations, Doctor Wyman could further stultify and demoralize the service by removing Doctor Kinyoun from San Francisco without a word. Can words foretell the possible consequence of such an act? It reeks with degradation of an honorable service, compromises honor and integrity, places a premium on inefficiency, neglect of duty, and dishonesty, and shows how a failure to be bribed, to be forced to violation of law, oath, and honor, is recompensed after almost twenty years of honorable service.

This phase of the question has been exceedingly puzzling. We have been unable to convince ourselves that Doctor Wyman, after public and private assurances of the utmost confidence in Doctor Kinyoun, after even assuring him on March 3 that he was prepared to meet any and all opposition, after being warned of the character of the California delegation, of their purpose, and of their unscrupulous and malicious methods, would sacrifice a friend and fellow-officer without apparent reason. On this account, and after a careful and thoughtful sifting of all the facts at our command, we have become fully convinced that this order relieving Doctor Kinyoun of his position at San Francisco was forced from Doctor Wyman by the California delegation, the instruments of Henry T. Gage and various commercial bodies. We have long believed that Doctor Wyman had been made to bear a burden that has brought consternation and dismay among those whom he controls. Our plea is not to shield him. We believe that he is guilty of the crime of concealment, that he deserves the severest censure for yielding to scurrilous politicians and heartless corporations, that he is being made the scapegoat in this affair, and that the influences that have brought around his head this measure of censure, will in derision and scorn gloat over the degradation of himself and the Marine Hospital Service. It is too plain now that the greater part of these efforts at concealment were the work of this delegation and one treasury official. The incident already mentioned shows that Mr. T. T. Williams, of the *Examiner,* made certain demands that Doctor Wyman could not yield to, unless held in his power; the telegrams of Mr. Older and Senator Perkins help to sustain this idea; the fact that the "understanding," which has been the cause of this discussion, was not written and signed, is an evidence that this delegation intended to use him as a shield to cover up their iniquity; and while we still maintain that he has grievously sinned, yet we are forced to pity him in his unenviable position.

The situation since our last issue has not changed. No cases of plague have been found. No deaths from acute disease have been recorded. Tuberculosis, syphilis, chronic appendicitis, perforation of the bowels, heart disease, and chronic nephritis have each secured their quota. No case of sickness resembling plague, in any shape or form, has been reported. Our apprehensions have been verified. Already certain individuals are proclaiming that there is no plague, that it has been wiped out, that their work is done, that disinfection and sanitation are not needed, that all efforts to find cases have been futile. Sixty days have passed, and we are safe. But Chinatown has not been cleaned. One-half has been put in fair condition; the remainder has not been touched, and, in all probability, will be left to reek in filth for all time. Our climatic conditions have not been favorable during the months of April and May of this year for the non-development of plague and acute diseases. The death rate is scarcely half that of the same months for the past five years. The reason for this is that certain factions are working together to conceal the true state of affairs, that they may maintain the assertions of certain political elements who said there never was any plague. So far the scheme has worked admirably, and once more the Marine Hospital Service of this country will, in all probability, be censured for wasting money in futile efforts to bolster up their "false and senseless claims."

## OUR COLLEGE COMMENCEMENTS.

Below will be found a list of those upon whom the title of Doctor of Medicine has been conferred by our two leading institutions. The fact that Cooper Medical College has been unable to fill the demand for internes made upon it, is a very high compliment to the excellent standing of that institution.

### MEDICAL DEPARTMENT, UNIVERSITY OF CALIFORNIA.

Edgar Allen Arthur, Wilfred Fenton Beerman, Ph. G., Kate Isabel Brady, A. B., Walter Murray Dickie, Ph. B., Ralph Orlando Dresser, John Nivison Force, B. S., Harold Phillips Hill, A. B., Reuben Chandler Hill, Mary Frances Kavanagh, Milton Byrne Lennon, M. A., John Vaughan Leonard, William Kinkade Lindsay, Rasmus Hansen Madsen, A. B., Florence McCoy, B. S., Frederic Lincoln Morong, William James Murphy, George Philip Purlenky, Ph. G., Fletcher Greene Sanborn, Lionel Samuel Schmitt, James Walter Seawell, Haydn Mozart Simmons, Ph. G., Hudson Smythe, George William Sweetser, Ph. G., Benjamin

Thomas, M. A., Joseph Michael Toner, John Lysander White, Chester Howard Woolsey, B. S., Una Yone Yanagisawa, B. L.

### COOPER MEDICAL COLLEGE.

Philip Fanning Abbott, A. B., Chad Evans Arnold, Herschel Hampton Brown, A. B., George Ryckman Carson, Albert Cohen, Carrie Clementine Cole, Lillian A. Dell, Richard John Dowdall, Ph. G., Frank Seely Emmal, Edith Sibyl Hammond, A. B., George Kramer Herzog, Paul Kingsley Jackson, Moses Jacobson, Alexander Simpson Kelly, William Lucas, Jr., Masaji Matsuda, D. D. S., Allen Bonner McConnell, James Edward McCue, William McDowell, Charles Edward Mooser, Charles Allen Poage, William Augustus Reckers, Paul Heron Reilly, Ph. G., Thomas Nelson Sample, Fred William Watt, Thomas Arthur Williams, Frank Zelinsky.

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## A REMINISCENCE OF DR. TOLAND.

The following passage, handed us by Dr. G. B. Somers, occurs in a tribute to the memory of Dr. J. Marion Sims, written by W. O. Baldwin, of Montgomery, Alabama, in November, 1883:—

"When Doctor Sims located in Montgomery, he had scarcely any income from his profession, and that being quite limited for the first year, he was sorely troubled, for a time, to meet his current expenses. But his was not a nature to be long discouraged. He was all zeal, energy, and pluck. Within a few months after he located here, the operations for club-foot and cross-eyes, the latter of which had but recently been devised by Dieffenbach, in 1839, and practised successfully by him, were creating quite a sensation in Columbia, South Carolina. Doctor Toland, then of that city, and now of San Francisco, had but recently returned from Paris, and was making quite a reputation as a surgeon by performing these operations in Columbia. I heard Doctor Sims read from a newspaper published in that city in 1841 the first account he had ever seen of the operation for cross-eyes, commenting most favorably upon Doctor Toland's success. This, I believe, was the starting-point of the great success of Doctor Toland as a surgeon."

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# SOCIETY PROCEEDINGS.

## SAN FRANCISCO COUNTY MEDICAL SOCIETY.

**Regular Meeting, May 14, 1901.**

The president, George H. Evans, in the chair.

### APPENDICITIS.

Dr. J. Mora Moss read a paper on "Appendicitis."

J. Henry Barbat: The following case is of interest on account of the rarity of the condition. Miss M., aged 23 years, gave the following history: On Jan. 15, 1894, she had a sudden sharp pain in the right iliac region, which spread over the whole abdomen, and which was diagnosed as idiopathic peritonitis. From this time on she suffered with severe headaches, and the pain in the iliac region has been persistent, with occasional exacerbations, at which time the pain would follow the course of the anterior crural nerve down the front of the thigh. On examination I found the abdomen very tender over McBurney's point, the uterus in normal position, the left ovary apparently normal; the right could not be palpated on account of the tenderness. A diagnosis of chronic recurring appendicitis was made, and operation advised, because the suffering was incapacitating the girl from attending to her studies. An inch and a quarter incision was made at the external border of the right rectus muscle, and the appendix removed. There was not much pathology apparent in the appendix itself, but the cecum near the base of the appendix was fully three-eighths of an inch thick, and prevented me from inverting the stump. The peritoneum covering the cecum was very loose and congested. As the patient had complained of increased pain before and after menstruation, I examined the uterus and adnexa, and was surprised to find that the right ovary was missing. After careful search, I found that the right tube was represented by a thin, fibrous cord, near the end of which was a small nodule, which is evidently a rudimentary ovary. The fimbriated extremity was adherent to the great omentum, which seemed to be tucked over on the left side, and it required considerable force to dislodge it and draw it out of the wound. The tube and a piece of omentum four inches long were removed. The specimen shows several interesting features; the portion which represents the tube is five cm. long and one cm. thick at its thickest part, which is near the center. At the point where the tube joined the uterus it was not more than two mm. in diameter. No opening could be found in the specimen, and the fimbriated extremity is represented by two small cysts, and has attached to it a strip of omentum, which is firmly adherent. The nodule representing the ovary is one and a half cm. long and not quite one cm. wide, and does not show the slightest sign of ovarian tissue, but consists of fibrous tissue.

Dr. J. H. Barbat (in reply to a question as to the cause of the pain): The pain was undoubtedly due to the adhesion of the omentum to the tube. We find that in the majority of cases in which we have adhesions of any of the abdominal viscera, there is pain, which is continuous or paroxysmal according to the character of the adhesions. In this case the adhesion of the omentum, which was drawn over to the left side, caused constant tension, which was increased by any distension of the bowels. The thickening of the cecum would also cause pain, as the spot was undoubtedly inflammatory in character. The patient has been free from pain since the operation.

Dr. Geo. B. Somers: I would like to ask if the shape of the uterus was perfectly normal.

Dr. J. H. Barbat: It was perfectly normal in shape, size, and position.

J. H. Barbat (in discussing Doctor Moss' paper): I will say a word with regard to appendicitis in connection with this subject. I have seen three or four cases in which neuralgia simulated an acute attack of appendicitis. There was a decidedly tender spot over McBurney's point, and the doctor in attendance felt certain that the patient was suffering from appendicitis. Careful examination showed that there was another tender spot near the spine, and, in one case, a second spot just over the middle of the crest of the ilium.

Dr. Chas. G. Levison: I regret exceedingly that Doctor Kugeler has not come, for I am much interested in this subject, to which he first called my attention, and, as he will not be here this evening, it might be well to give a description of the procedure as first advocated by Schleich. The following is the formula of the paste:—

Acacia, 30.0; Peptone Meal, 15.0; Zinc Oxide, 15.0; Starch, 15.0; Lysol, .6; Ol Citron, .6.

This form of peptone is not found in drug stores generally, being usually obtained from dealers in bacteriological supplies. This mixture is first carefully rubbed up in a large mortar, with about 30.0 water, until a smooth paste results. A piece of gauze is cut slightly larger than the ulcer, which is then covered with the gauze; upon this the paste is applied, as well as on the entire naked leg. The leg is covered with paste from knee to ankle. It is best spread by means of a spatula. Over this paste a dry gauze bandage is firmly wound from foot to knee, and upon this a wet starch bandage is applied. The dressing is then allowed to harden, which usually takes twenty minutes, after which the patient can go about his business. The intolerable itching, of which so many of these patients complain, and which is frequently the cause of these ulcers persisting, is relieved as if by magic. It is well known that frequently ulcus cruris is easily healed, only to be torn open again by the patient scratching while asleep. In many of these cases there is an elephantiasis, due to the chronic edema. This condition is at once relieved, on account of the improvement in this lymphatic circulation. The bandage remains indefinitely, only changing it as the edema disappears, which results in the loosening of the bandage. As the bandage becomes soaked with the discharge, a window can be cut out, and through this the ulcer can be treated with various applications. Yesterday I applied the dressing to a man weighing 280 pounds, who had not passed a comfortable night for months on account of pain and itching. To-day he remarked that last night was the first comfortable night he had experienced for a long time; this was due to the freedom from itching and pain. The first case I treated was an ulcer of 18 years' duration. This was healed within 6 weeks. My experience now comprises 20 cases, 19 of which have been treated, with gratifying results, all having been healed. In the single case where the bandage was applied, and which was seen by Doctor Terry, no effect was produced. In this case the woman's leg was so large that the bandage never was properly applied. I am sorry that Doctor Montgomery is not here, as I know he has used this method with good result.

Dr. J. Henry Barbat: I would like to ask if the action of this is only to equalize the pressure, or if it has any specific effect on the ulcer.

Dr. C. G. Levison: It does not come in contact with the ulcer at all.

Dr. J. H. Barbat: Can you figure out the action of it?

Dr. C. G. Levison: It stops the itching.

Dr. J. H. Barbat: But what is the action of the paste? what therapeutic action has it?

Dr. C. G. Levison: The pressure is equalized. It forms a covering as firm as plaster of Paris, but still it is elastic, and the patient will return again and again to have it applied, as it relieves at once, and it can be worn for an indefinite period.

## THE CALIFORNIA ACADEMY OF MEDICINE.

**Regular Meeting, April 30, 1901.**

The president, Dr. D. W. Montgomery, presiding.

### TERATOMA.

Dr. James F. McCone presented a case of sacral teratoma, as follows: The fetus was one of the twins. Its parents were not consanguinously related, and neither had suffered from infective fevers. The tumor grew from the post anal region, and was in no way intimately connected with alimentary canal, or with sacrum, or coccyx. The tumor was a flattened spheroidal mass, 10 cm. in diameter, 6 cm. in thickness. It presented microscopically many varieties of tissue, areolar, myxomatous, glandular, nervous, muscular, etc. One part of the tumor had the general structure of small intestine, with its mucous membrane, villi, lymphoid follicles, and muscularis mucosa.

Dr. C. A. von Hoffmann also exhibited a teratoma arising from the superior and inferior maxillae tissues of the neck and sternum. Its largest circumference was twelve inches, and its circumference at its root was eleven inches. The mother was a strong woman, 29 years of age, who had had a normal confinement in 1887. The monstrosity presented was born Dec. 23, 1900. It interfered somewhat with the passage of the head through the pelvis, which required the assistance of forceps. The placenta was small and the puerperium normal. He examined her on January 30, and found involution complete.

Dr. Montgomery said that he had seen a very interesting case of teratoma some years ago in the practise of Dr. McNutt, which differed from those usually seen in being malignant. It was situated on the abdomen, and caused the death of its host. They frequently appear at the sacral and occipital regions, which, he thought, were their most frequent location. They have to do with the embryonic layers, and contain enormous numbers of tissues. Some look like separate beings glued to the fetus.

Dr. McCone protested against the name of sacral being given to these tumors, for they are in no way connected with the sacrum. It was the region where they appear, and not the tissue of which they are formed, which had given them this name.

Dr. Brunn said that teratomas of the sacral region were more common than those exhibited to-night by Doctor von Hoffmann, those having the location of the latter specimen being quite rare. Sacral teratoma did not arise from the sacrum, but from the post anal region. This one had no connection with the sacrum or coccyx.

### SUBPHRENIC ABSCESS.

Dr. T. W. Huntington reported the following case: On April 17, 1901, the patient, A. M. T., was admitted to the medical service at the City and County Hospital. The following history was recorded: Male, born in Illinois, age 54, occupation canvasser. Father died of tubercular disease. Family history otherwise unimportant. Uses alcohol and tobacco moderately. Previous history insignificant. Five days prior to admission was seized with violent cramps in upper abdominal region, attended by nausea. Hypogastric pain continued, and was present at first examination. There was persistent hiccough for first two days, which ceased spontaneously. Abdomen distended noticeably. Bowels constipated, suggesting partial obstruction. Pain gradually increased. Heart seemed slightly displaced to the left. Slight dulness at left apex. Excursion of diaphragm not made out. Liver dulness could not be outlined. Spleen enlarged. Urinary examination negative. Leucocytes 6,400. The patient was transferred to my service April 23, 1901, without definite diagnosis. On examination the entire abdomen was found to be distended, tympanitic, and acutely sensitive. Patient seemed to be in great pain, but painful area had no definite limits. The distension over the region of the gall bladder was markedly greater than at any other point, amounting to a positive elevation of the abdominal wall at that point. Over this area there was tympanitic resonance, which extended laterally to the axillary line. From this point posteriorly there was dulness. The temperature had ranged from 99 degrees to 100 degrees. Pulse full, rapid, and rebounding. Leucocyte count 14,400. Exploration was advised. The patient assenting, chloroform was administered, and a vertical incision was made on the outer side of the right rectus, below the costal margin. On opening the peritoneum, there was an escape of a considerable amount of gas. Thinking that there must be communication with the general cavity, I resected a small portion of the eighth rib in the axillary line, but at once found the diaphragm lying against the chest wall, and apparently acting as a barrier. This wound was accordingly closed. The abscess cavity was then drained, the original wound partly closed, and frequent irrigation of the cavity ordered. Patient rallied fairly well. Since the operation the temperature has ranged from 102 degrees to 104 degrees. There has been a free discharge of pus. The patient has taken nourishment and stimulation freely. The diagnosis in this case was never made with any definiteness until an exploratory incision made a demonstration possible. The presence of gas, overlying the pus reservoir and crowding outward the containing wall, was a marked feature. Probably a more careful examination of the patient in different postures would have suggested the presence of pus in large quantities, but the patient's condition was such as not to warrant prolonged examination. The origin of the abscess is still a matter of some doubt. From the first my suspicions were centered upon the gall bladder, although the patient's history in no definite matter warranted this hypothesis. Careful search was made during the operation for the gall bladder, but it could not be found.

The sudden onset of the original attack furnishes grounds for assuming the presence of a perforating ulcer of the stomach, pylorus, or duodenum. Subphrenic abscess, or collections of pus within the lesser peritoneal inclosure, may originate variously. They may be primary, that is, have their origin in lesions of the stomach, pylorus, duodenum, transverse colon, liver, gall bladder, lungs, pleura, or pericardium. Keen reports one case as probably originating in the spleen, as a sequel of typhoid fever. Osler and Sampe state that suppurative appendicitis is a frequent primary cause. Secondarily, this condition may result from septic foci in the liver, which are metastatic manifestations following infective processes in the remote organs. It seems probable that septic venous thromboses may occur in this locality outside of the liver, but this statement lacks confirmation on the part of observers. In one of my own cases a subphrenic abscess occurred seven days after the evacuation of an appendicular abscess. Surgical interference resulted in marked improvement temporarily, but the patient finally succumbed to a similar pulmonary involvement. Baldin, of Columbus, Ohio, last year reported two cases of secondary subdiaphragmatic abscess, following appendicular perforation. The first became manifest fourteen days and the second twenty-one days after an operation for the original trouble. Surgical interference resulted favorably in each case.

Dr. J. H. Barbat said that this case was of peculiar interest to him. The gas having a fecal odor might suggest the probability of the abscess being an appendicular one. Several years ago he had had a subphrenic abscess in his own person, which had been incised and drained, and enormous quantities of pus removed. It had finally healed over, but some years later he had had a well-marked attack of appendicitis. His abdomen was opened, and a much-thickened and firmly-adherent appendix, situated behind the cecum, was removed. These adhesions were very dense, showing that they had existed for a long time. It was his opinion that his previous abscess originated in his appendix.

Dr. H. M. Sherman said that he had seen an item within the last six or eight weeks, in some journal, that subphrenic abscesses never follow appendicitis. He was able to refute that statement, however, as he had just lost such a case. He thought the presence of gas in Doctor Huntington's case would suggest a perforation of the duodenum or stomach.

Dr. Philip King Brown said that he had autopsied two cases; one was a subdiaphragmatic and pleural abscess, following appendicitis, and subsequently discharging through the mouth. The other case had followed more directly Doctor Huntington's report. It was a case of duodenal ulcer.

Doctor von Hoffman said that when he found a collection of pus behind the ascending colon, outside the peritoneum, he thought it very unlikely that the pus could come from an appendicitis, but thought that these cases could be better explained by direct infection from the colon. Men should be more careful in their examinations of these cases.

Doctor Brunn had seen some subdiaphragmatic abscesses from appendicitis. He had autopsied also a case of fibroid tumor of the uterus, which had been treated by electricity, and where an abscess was found in the uterus, and was followed by a subdiaphragmatic abscess.

Doctor Huntington, in closing, said there was no history of appendicular involvement; he had eliminated that. He had two theories to present as a cause; the first, that it was a ruptured gall bladder, and the second, a perforation of the duodenum.

Dr. Dudley Tait had seen last year two cases in which a diagnosis of syphilis of the kidney had been made. One occurred six weeks after the appearance of the chancre, which suddenly developed a very intense nephritis, and the patient died of uremia. There was never less than twenty grams of albumen to the liter. Autopsy showed a typical white kidney. The second case was a mild one, similar to that reported by Doctor Montgomery. The albumen disappeared with mercurial treatment; no iodides were given. He thought the fear of giving mercury in these kidney cases was not well founded. A peculiar feature was the large amount of albumen present.

Doctor Huntington thought that this was a case where surgical interference would be available, and justified the propriety of using Thiersch grafts. He had seen a much more aggravated burn, which was as large as a dinner plate, over the lower part of the abdomen. The patient was still suffering from the burn. It might be that grafts would not thrive, but he certainly thought the effort would be justifiable.

Doctor Barbat had read reports of grafting, but none of them had been successful, not even after deep cutting. The case of Doctor Montgomery's, he thought, was of interest because the patient had been burned by rays produced from a static machine, the advocates of which claim that burns do not occur when it is employed. The best local treatment he had found was from the use of an ointment made of orthoform and europhen.

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## THE SAN FRANCISCO MEDICO-CHIRURGICAL SOCIETY.

**Regular Meeting, April 1, 1901.**

### HYDROCELE OF INFANTS.

Dr. F. P. Gray: I have recently seen, in the children's clinic at the college here, four cases of hydrocele in young children. The first one was tapped, and, after the tapping, a little fluid remained. Then some carbolic acid pure, in liquid form, was introduced, about ten minims in quantity, and the scrotum manipulated so as to distribute the acid as well as possible over the tunica vaginalis. In this case there was no inflammatory reaction, and recovery was satisfactory. There was no recurrence. The second case, two years old, was also tapped; about two drams of fluid came away. Then there was introduced, as in the first case, about ten minims of liquid carbolic acid, and this was, as in the previous case, moved about inside the scrotum so as to distribute itself as well as possible over the inner wall of the tunica vaginalis. There was much inflammatory reaction following, for which hot applications were used. It left the left side of the scrotum larger than the right side, but recovery was fairly satisfactory. The third case was a so-called double hydrocele of the sac and of the cord. This was in a child two weeks old. It was tapped, and in a few days the fluid reaccumulated. It was then painted with collodion; but this was not satisfactory, for in a short time the collodion peeled off. The case was finally lost sight of, recovery not having taken place, nor was there any perceptible benefit from the treatment. In the fourth case, one in private practise, the expectant method of treatment was followed, and the child, also an infant, recovered without any surgical intervention.

Dr. C. N. Ellinwood: I thought that this method of injection into the hydrocele sac had long been abandoned. Experiments have proven that where the tunica is very thick, as is shown clinically by the absence of translucency, no injection method is ever successful; but, where the sac is translucent, this method, especially where bichlorid of mercury is used, is successful. In the cases that are so old, and the sac is so thick that light will not show through it, the open method is to be followed; because, as I have said, the injection method is, in this class, not only wrong theoretically, but has been shown to be wrong in practise.

Dr. R. L. Rigdon: It often happens that fluid is in more than one sac, and consequently when the canula is introduced, it drains one cavity only, and the tumor does not wholly disappear. Very often we can drain effectively by pushing the needle in different directions about the inside of the scrotum, and thus enter the different cavities without making more than one wound through the skin. This, however, does not succeed in all cases. Keyes, of New York, claims that the injection method will, with the use of carbolic acid, cure ninety per cent of cases. Whether this is the judgment of all practitioners who use the method, I do not know. In the selection of cases much judgment must be used. It can easily be seen that the method will not succeed unless the walls are collapsible; this is necessary, in order that they agglutinate after the introduction of the acid. Every substance almost that can be thought of, has been used in lieu of carbolic acid, even, to very lately, the insertion of sterilized catgut, the idea being to make it coil up inside the sac, after pushing it through the canula. I believe, from reading and from experience, however, that carbolic acid is the best substance to use, and the case which I report to-night is the only one in which I have ever had trouble after that method of treatment.

### WIDESPREAD STAPHYLOCOCCUS INFECTION.

Dr. William Ophuls: The autopsy from which these specimens were taken was performed this morning. Unfortunately there is no clinical history to be obtained. The patient was a Chinese, well built, but very emaciated. Lungs.—There is no trouble here, except strong adhesions to the diaphragm. The only other change that has taken place is a slight bronchitis. Spleen.—This is connected with the pancreas, with the diaphragm, and with the kidney, and contains many small abscesses with pus in them, and here an infarction. It is surrounded by scar tissue. The left kidney is adherent to the diaphragm, and around the kidney there is pus, and we find here a stone in the pelvis of the kidney. The pelvis of the kidney is much distended, its cortex greatly reduced. Inflammation extends from the pelvis downward into the upper two-thirds of the ureter. Bladder.—This is small, and contains one dram of pus. Inflammation seems to have traveled up the other side, and to have caused in the other kidney a few small hemorrhages. There is in this right kidney a small abscess, but otherwise it seems healthy. Alimentary canal, stomach.—On the lesser curvature is a large ulcer, and also on the posterior wall of the stomach an ulcer. Small intestine appears to be normal. Large intestine.—Here the mucous membrane is destroyed almost entirely, and there is an extensive deposit of pseudo membrane on the inner surface of the bowel. The lesions here are numerous, and strikingly large and destructive. The case is a difficult one to explain. Any explanation, or, in fact, all of the explanations which I have been able to devise, are not entirely satisfactory. There seems to me to have been the first change in the left kidney. Here there was nephrolithiasis, with not an entire destruction of the kidney. There followed from this hydronephrosis, then infected urine, then an inflammation of the kidney substance, following this perinephritis, then, by extension, involvement of the spleen; thence the inflammation spread outward, fastening the spleen and the kidney together in a mass of adhesions. Then came, perhaps, the infarction, and also, by extension upward, the pleuritis and the adhesion to the diaphragm. In the stomach the changes, I think, were also secondary. There was apparent an extensive hemorrhage, from some cause, in the mucous membrane—perhaps an infarction—then digestion of the mucous membrane; thus are explained the ulcers on its surface. The infection of the other kidney was probably an ascending one. The other changes can not be so easily explained. The pus certainly did not go directly from the left kidney to the large intestine through abscess perforations. It is too widespread for such an explanation; and then the organisms could not get directly into the intestine from this kidney. The complication is very unusual. In most cases of nephrolithiasis the organism at fault is the colon bacillus, but in this case the staphylococcus is the organism. It seems as if the same cause were acting in all the lesions, but it is rather unusual to find the staphylococcus in the large intestine.

Doctor Hirschfelder suggests that perhaps the intestinal lesion was the primary one, and that the other one was a secondary infection, set up through the urethra; however this may be, the most interesting thing pathologically is the extensive ulceration that has followed the hemorrhage under the mucous membrane of the intestine. I have seen somewhat similar pictures presented in the autopsy room before, but I have never seen so extensive an ulceration of the large intestine as is here presented, and I never remember to have seen the staphylococcus as the cause of it.

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**Regular Meeting, May 6, 1901.**

Dr. A. W. Perry in the chair.

### HEROIN; THE NEWER SILVER SALTS; THE INTESTINAL ANTISEPTICS.

Dr. G. F. Hanson read a paper with above title (to be published).

Dr. J. O. Hirschfelder: I am very glad to confirm the statement of Doctor Hanson, especially with regard to heroin. My experience with the drug has been largely in diseases of the respiratory organs. It has in my hands all the beneficial effects of morphin, and in the small doses mentioned by Doctor Hanson, I have seen none of its unfavorable effects, except, very rarely, vomiting. I have had no experience with it as a narcotic. With regard to the silver salts, I would like to call attention to, not a new salt, and yet one which is not, at least very widely, known. I refer to the hyposulphite of silver and sodium. I have been experimenting with a number of these drugs for about fifteen years, first with platinum, which was disappointing in its action; then with gold; then with copper, both of which were not encouraging drugs to use; and finally with silver. In the form above mentioned, I have given as much as six grains of the silver hyposulphite every two hours in typhoid fever. This is not a usual dosage. The ordinary dose is considerably smaller, and yet, little by little, the dose was increased, until, as I say, this dosage was reached, without ill effects. Indeed, I saw no directly unpleasant effects from the use of the salt. The clinical experience that I have had with it has been, however, such as to make me hesitate in the use of the drug in typhoid fever. On the subject of intestinal antiseptics I agree with others that perfect sterilization of the intestinal canal is impossible. My experience with the newer salts has been that, like those of bismuth, they are not of very much value. They certainly do not destroy the bacteria in the intestines, and we may safely say that we have yet to find the substance that will do so.

Henry Gibbons, Jr.: I have used heroin in cough mixtures. I can not praise it. For many years I have used in acute cough affections morphia, $\frac{1}{32}$ of a grain, in syrup of wild cherry and tolu, and, in comparison with this mixture, I do not think that heroin, in any combination that I have used, produces as good an effect. Used in this dose, there is very rarely nausea, and almost never constipation. With regard to the use of the newer silver salts in the intestinal canal, I have had no experience; nor have I obtained particularly good effects with the newer bismuth salts. Of the older ones, I prefer the subnitrate, given in quite large doses, and frequently repeated. While not directly coming under consideration, yet I would like to take this opportunity of saying that I have used, with much satisfaction, naphthol, two grains every three hours, in chronic and even in acute cystitis.

Doctor Perry: I have found, where in acute disease of the respiratory passages the cough is out of proportion to the secretion, that an excellent sedative effect is obtained with small doses of chloral,—about three grains every three hours; where the cough is not out of proportion to the secretion, it is better to do nothing. I have had but little experience with protargol. Intestinal antisepsis I consider as nonsense. Where there is stagnation in the small intestine, much harm follows to the body at large.

Where there is stagnation in the large intestine, no particular harm is done. The carbohydrates prevent stagnation in the small intestines. We can reduce the number of bacteria and the amount of intestinal fermentation, as shown by a diminution of the ethereal sulphates in the urine, by frequent evacuation of the bowels, and by an exclusive milk diet, with sugar of milk present in the food given. In this way the carbohydrate is supplied to the small intestine, and, as I have said, prevents the multiplication of bacteria in the small intestine. This has been proven experimentally as well as clinically. It is my experience that attempts at intestinal antisepsis by drugs have been utter failures.

Doctor Hanson: The gentleman on my right says to me, sotto voce, "What is the matter with calomel?" Now, calomel is not in itself an antiseptic; but it acts antiseptically, by causing more bile to flow down through the intestinal canal than had been flowing previous to the administration of the drug. There are, undoubtedly, some intestinal antiseptics which reduce the number of bacteria in the intestines, but they do not do so by destroying the bacteria. The principal value of intestinal antiseptics is their inhibiting action after some other drug has cleared the intestine of the accumulated supply that is already there.